

TRANSITION AND WELLBEING RESEARCH PROGRAMME

FAMILY WELLBEING STUDY

Part 1

Families of Current and Ex-Serving ADF Members:
Health and Wellbeing

Part 2

Military Family Approaches to Managing Transition
to Civilian Life



2018

ISBN 978-0-6481608-6-1 (PDF)
ISBN 978-0-6481608-7-8 (Print)

© Commonwealth of Australia 2018

Unless otherwise noted, copyright (and other intellectual property rights, if any) in this publication is owned by the Commonwealth of Australia.

With the exception of the Coat of Arms and all photographs and graphics, this publication is licensed under a Creative Commons Attribution 3.0 Australia licence. The Creative Commons 3.0 Australia licence is a standard form licence agreement that allows you to copy, distribute, transmit and adapt this publication provided that you attribute the work. The full licence terms are available from www.creativecommons.org/licenses/by/3.0/au/legalcode.



Suggested citations

Daraganova, G., Smart, D., & Romaniuk, H. (2018). *Family Wellbeing Study: Part 1: Families of Current and Ex-Serving ADF Members: Health and Wellbeing*. Canberra: Department of Defence and Department of Veterans' Affairs.

Muir S. (2018). *Family Wellbeing Study: Part 2: Military Family Approaches to Managing Transition to Civilian Life*. Canberra: Department of Defence and Department of Veterans' Affairs.

Disclaimer: Views expressed in this report are those of the individual authors and may not reflect the views of the Australian Government, including the Australian Institute of Family Studies, the Department of Defence and the Department of Veterans' Affairs.

Requests and enquiries concerning reproduction and rights should be addressed to:

Publications Section
Department of Veterans' Affairs
GPO Box 9998
Canberra ACT 2601

or emailed to publications@dva.gov.au.

This study is available from:

Department of Defence
www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp

Department of Veterans' Affairs
www.dva.gov.au/family-wellbeing-study

Published by the Department of Veterans' Affairs.

Publication no: P03641

Contents

Acknowledgements.....	xi
PART 1 Families of Current and Ex-Serving ADF Members: Health and Wellbeing.....	1
Executive summary	3
1 Introduction	11
1.1 Transition and Wellbeing Research Programme – an overview	11
1.2 Family Wellbeing Study.....	13
1.3 Overview of knowledge about military families and their wellbeing.....	15
1.4 Aims, objectives and scope of Part 1	41
2 Methodology.....	45
2.1 Study design – recruitment of sample	45
2.2 Families in focus.....	46
2.3 Nomination and response rates for the FWS.....	49
2.4 Representativeness of MHWTS respondents with family data	51
2.5 Number of nominations by MHWTS respondents	57
2.6 Relationship of FWS participants to their MHWTS respondents	58
2.7 Differing samples used in statistical analyses	60
2.8 Differences between MHWTS respondents with and without FWS data, by family relationship	61
2.9 Measures used in Part 1	75
3 Health and wellbeing of FWS military families.....	91
3.1 Meet the families.....	91
3.2 How were military spouses/partners faring?.....	106
3.3 How were the adult children of ADF members faring?.....	149
3.4 How were the parents of ADF members faring?.....	159
4 Factors associated with military families’ health and functioning	175
4.1 Method	175
4.2 Samples and variables used in multivariate analyses of family members’ mental health and problem drinking	181

4.3	Findings from the multivariate modelling of mental health outcomes and problem drinking	183
4.4	Samples and variables used in the multivariate modelling of couple relationships	191
4.5	Findings from the multivariate modelling of couple relationships	193
4.6	Samples and variables used in the multivariate modelling of parenting practices.....	201
4.7	Findings from the multivariate modelling of parenting practices	203
4.8	Samples and variables used in the multivariate modelling of child total behaviour problems	218
4.9	Findings from the multivariate modelling of child total behaviour problems.....	220
4.10	Summary	223
5	Discussion	231
5.1	Representativeness of the FWS sample	232
5.2	What is the overall health and wellbeing of Australian military families?	234
5.3	Were there differences between families of Current Serving and Ex-Serving ADF members?.....	246
5.4	What is the effect of military service on families?	251
5.5	Help seeking, barriers and unmet need.....	253
5.6	Implications of the multivariate modelling.....	255
5.7	Limitations	263
5.8	Conclusions and implications	264
Appendix A	Data collection methodology	267
Appendix B	Details of nomination and response rates for MHWTS and FWS respondents, by MHWTS military status	269
Appendix C	Effects of military service, perceptions of all FWS respondents	271
Appendix D	Effects of military service, perceptions of spouses/partners	275
Appendix E	Effects of military service, perceptions of adult children	281
Appendix F	Effect of military service, perceptions of parents	285
Appendix G	FWS and MHWTS respondent measures by mental health outcomes.....	289
Appendix H	FWS and MHWTS respondent measures by couple relationship outcomes 293	
Appendix I	FWS respondent and ADF member measures by parenting practices outcomes 297	

Appendix J	FWS and MHWTS respondent measures by total behaviour problems in children aged 2 to 17 years.....	303
	Acronyms and abbreviations	305
	Glossary	307
	References	309
	PART 2 Military Family Approaches to Managing Transition to Civilian Life	331
	Key findings.....	333
6	Introduction	335
	6.1 Background to the study.....	335
	6.2 Family Wellbeing Study: Part 2: Military Family Approaches to Managing Transition to Civilian Life.....	336
	6.3 Structure of Part 2	337
7	Study design and research methods	339
	7.1 Sampling and recruitment	339
	7.2 Research methods	342
8	The context of family involvement: Transition challenges and expectations.....	345
	8.1 Transition challenges	345
	8.2 Other factors in transition experiences	349
	8.3 Transition expectations: What is a ‘successful’ transition?	355
9	The role of families in Defence member transition	359
	9.1 Transition planning	360
	9.2 Family life and emotional support	363
10	Improving transition outcomes	367
	10.1 What families can do	367
	10.2 Family desires for support	374
11	Discussion	379
	11.1 Summary of the research findings and their implications	380
	References	383

Tables

Table 1.1	Transition and Wellbeing Research Programme objectives and Studies and reports	12
Table 2.1	Military status of MHWTS respondents with eligible nominations	48
Table 2.2	Number of nominations provided, by MHWTS respondent type	58
Table 2.3	FWS samples derived for FWS data analysis	61
Table 2.4	Characteristics of Current Serving MHWTS respondents with and without FWS data	63
Table 2.5	Characteristics of Ex-Serving MHWTS respondents with and without FWS data	65
Table 2.6	Characteristics of Current Serving MHWTS respondents with and without spouse/partner data	66
Table 2.7	Characteristics of Ex-Serving MHWTS respondents with and without spouse/partner data	67
Table 2.8	Characteristics of Current Serving MHWTS respondents with and without parent data	69
Table 2.9	Characteristics of Ex-Serving MHWTS respondents with and without parent data	70
Table 2.10	Characteristics of Current Serving MHWTS respondents with and without adult child data	72
Table 2.11	Characteristics of Ex-Serving MHWTS respondents with and without adult child data	73
Table 2.12	Demographic and service factors on which MHWTS respondents with and without different types of FWS data significantly differed	74
Table 2.13	Demographic characteristics	76
Table 2.14	Living arrangements and experiences of being without a permanent place to live	78
Table 2.15	Employment circumstances and financial hardship	79
Table 2.16	Military service characteristics and impact of service	80
Table 2.17	Couple relationships	82
Table 2.18	Parenting practices and parental self-efficacy	82
Table 2.19	Child behaviour problems and competencies	83
Table 2.20	Involvement in risk-taking	84
Table 2.21	Mental and physical health, traumatic events, concerns about mental health	85
Table 2.22	Help seeking and pathways to care for mental health problems	87
Table 3.1	Demographics of FWS participants, stratified by ADF members' military status	93
Table 3.2	Living arrangements of ADF members and FWS participants, stratified by ADF members' military status	94
Table 3.3	FWS participants' employment characteristics, stratified by ADF members' military status	95

Table 3.4	Military service history of ADF members and FWS participants, stratified by ADF members' military status	96
Table 3.5	Personal characteristics of spouses/partners, stratified by military status of ADF member	108
Table 3.6	Living arrangements of ADF members and spouses/partners, stratified by military status of ADF member	109
Table 3.7	Being without a permanent place to live among spouses/partners, stratified by military status of ADF member	111
Table 3.8	Spouses'/partners' employment, stratified by military status of ADF member	112
Table 3.9	Spouses'/partners' income sources and experience of financial hardships, stratified by military status of ADF member	113
Table 3.10	Residential mobility among civilian spouses/partners, stratified by military status of ADF member	115
Table 3.11	Residential mobility among spouses/partners who had served in the ADF, stratified by military status of ADF member	116
Table 3.12	Reasons for the most recent move, stratified by military status of ADF member	117
Table 3.13	Number of schools attended by school-age FWS children, stratified by military status of ADF member	118
Table 3.14	Military service history of ADF members and spouses/partners, stratified by military status of ADF member	119
Table 3.15	Relationship quality according to spouses/partners and ADF members – abuse in relationships, stratified by military status of ADF member	125
Table 3.16	Child demographics, stratified by military status of ADF member	126
Table 3.17	Spouses'/partners' parenting practices, stratified by military status of ADF member	126
Table 3.18	Socio-emotional adjustment of children aged 2 to 17 years, stratified by military status of ADF member	127
Table 3.19	Spouses'/partners' physical health and quality of life, stratified by military status of ADF member	128
Table 3.20	Spouses/partners' exposure to trauma, stratified by military status of ADF member	129
Table 3.21	Spouses'/partners' involvement in risk-taking, stratified by military status of ADF member	130
Table 3.22	Spouses'/partners' mental health, stratified by military status of ADF member	131
Table 3.23	Spouses'/partners' concerns about their own mental health, stratified by military status of ADF member	133
Table 3.24	Types of problems leading to help seeking among spouses/partners who expressed concerns about their mental health and had sought help, stratified by military status of ADF member	134
Table 3.25	Types of diagnosed mental health conditions, stratified by military status of ADF member	135

Table 3.26	Self-help sources used by spouses/partners, stratified by military status of ADF member	136
Table 3.27	Spouses'/partners' perceived barriers and stigmas to receiving care for own mental health problems, stratified by military status of ADF member	137
Table 3.28	Concerns about ADF members' mental health reported by spouses/partners – assistance provided, stratified by military status of ADF member	138
Table 3.29	Mental health problems of ADF members as reported by spouses/partners, stratified by military status of ADF member.....	141
Table 3.30	Adult children's personal characteristics and military service, stratified by military status of ADF member.....	150
Table 3.31	Adult children's physical health and quality of life, stratified by military status of ADF member.....	154
Table 3.32	Adult children's involvement in risk-taking, stratified by military status of ADF member	155
Table 3.33	Adult children's mental health, stratified by military status of ADF member	156
Table 3.34	Adult children's concerns about their own mental health, stratified by military status of ADF member.....	156
Table 3.35	Concerns about ADF members' mental health (adult child perspectives), stratified by military status of ADF member	157
Table 3.36	Parents' personal characteristics and military service, stratified by military status of ADF member.....	161
Table 3.37	Parents' physical health and quality of life, stratified by military status of ADF member	166
Table 3.38	Parents' involvement in risk-taking, stratified by military status of ADF member	167
Table 3.39	Parents' mental health, stratified by military status of ADF member	168
Table 3.40	Parents' concerns about their own mental health, stratified by military status of ADF member.....	169
Table 3.41	Concerns about ADF members' mental health reported by parents and assistance provided, stratified by military status of ADF member	170
Table 4.1	Summary of FWS respondent measures used in each analysis	179
Table 4.2	Summary of ADF member measures used in each analysis	179
Table 4.3	FWS respondent and ADF member characteristics (n = 1,143)	182
Table 4.4	Percentages showing problematic outcomes.....	183
Table 4.5	FWS respondent and ADF member predictors of FWS respondents' psychological distress	185
Table 4.6	FWS respondent and ADF member predictors of FWS respondents' PTSD	187
Table 4.7	FWS respondent and ADF member predictors of FWS respondents' problem drinking.....	189
Table 4.8	Spouse/partner and ADF member characteristics (n = 803)	191
Table 4.9	Frequency of outcomes (n = 803).....	192

Table 4.10	FWS spouse/partner and ADF member predictors of an unhappy couple relationship	195
Table 4.11	FWS spouse/partner and ADF member predictors of relationship quality	197
Table 4.12	FWS spouse/partner and ADF member predictors of abuse in current couple relationships.....	199
Table 4.13	FWS spouse/partner and ADF member characteristics (n = 428)	202
Table 4.14	Parenting practices outcomes (n = 428)	202
Table 4.15	FWS spouse/partner and ADF member predictors of parenting self-efficacy.....	204
Table 4.16	FWS spouse/partner and ADF member predictors of parenting consistency	207
Table 4.17	FWS spouse/partner and ADF member predictors of parenting hostility	210
Table 4.18	FWS spouse/partner and ADF member predictors of parenting use of reasoning	213
Table 4.19	FWS spouse/partner and ADF member predictors of parenting warmth.....	216
Table 4.20	FWS spouse/partner and ADF member characteristics (n = 420)	219
Table 4.21	FWS spouse/partner and ADF member predictors of child total behaviour problems.....	221
Table 4.22	Summary of factors associated with family members' mental health outcomes and problem drinking.....	223
Table 4.23	Summary of factors associated with couple relationship outcomes	225
Table 4.24	Summary of factors associated with spouses'/partners' parenting of children aged 2 to 17 years.....	228
Table 4.25	Summary of factors found to be significant predictors of one or more indicators used to assess the major areas examined.....	229
Table B.1	Current Serving ADF members	269
Table B.2	Ex-Serving ADF members.....	270
Table C.1	Effect of military service on ADF members, stratified by military status of ADF member	271
Table C.2	Effect of FWS respondents' own current or former military service on themselves, stratified by military status of ADF member	273
Table C.3	Effect of ADF members' military service on civilian FWS respondents, stratified by military status of ADF member	274
Table D.1	Effect of military service on ADF members, stratified by military status of ADF member	275
Table D.2	Effect of ADF members' service on civilian spouses/partners, stratified by military status of ADF member	277
Table D.3	Effect of spouses'/partners' own current or former military service on their own wellbeing, stratified by military status of ADF member	279
Table E.1	Effect of military service on ADF members (adult children perspectives), stratified by military status of ADF member	281
Table E.2	Effect of ADF members' service on their civilian adult children, stratified by military status of ADF member	283

Table F.1	Effect of military service on ADF members (parents' perspectives), stratified by military status of ADF member	285
Table F.2	Effect of ADF members' service on civilian parents, stratified by military status of ADF member	287
Table G.1	FWS respondent and ADF member measures, stratified by FWS respondents' psychological distress	289
Table G.2	FWS respondent and ADF member measures, stratified by FWS respondents' high levels of posttraumatic stress disorder (PTSD) symptoms	291
Table G.3	FWS respondent and ADF member measures, stratified by FWS respondents' problem drinking	292
Table H.1	Spouse/partner and ADF member measures, stratified by happiness in the couple relationship	293
Table H.2	Couple relationship quality by spouse/partner and ADF member measures	295
Table H.3	Spouse/partner and ADF member measures, stratified by the occurrence of abuse at some stage of the couple relationship	296
Table I.1	Parenting self-efficacy by spouse/partner and ADF member measures (n = 428)	297
Table I.2	Parenting consistency by spouse/partner and ADF member measures (n = 420)	298
Table I.3	Parenting hostility by spouse/partner and ADF member measures (n = 422)	299
Table I.4	Parenting use of reasoning by spouse/partner and ADF member measures (n = 420)	300
Table I.5	Parenting warmth by spouse/partner and ADF member measures (n = 427)	301
Table J.1	Spouse/partner and ADF member measures, stratified by child total behaviour problems	303
Table 7.1	Participant characteristics	342

Figures

Figure 1.1	Transition and Wellbeing Research Programme overview	11
Figure 2.1	Recruitment steps for the Family Wellbeing Study	47
Figure 2.2	Nomination rate and FWS response rate for families of Current Serving MHWTS respondents	50
Figure 2.3	Nomination rate and FWS response for families of Ex-Serving MHWTS respondents	51
Figure 2.4	Representativeness of MHWTS responding sample with family data, by age of MHWTS respondents	53
Figure 2.5	Representativeness of MHWTS responding sample with family data, by sex of MHWTS respondents	54
Figure 2.6	Representativeness of MHWTS responding sample with family data, by rank of MHWTS respondents	55

Figure 2.7	Representativeness of MHWTS responding sample with family data, by type of service of MHWTS respondents	56
Figure 2.8	Representativeness of MHWTS responding sample with family data, by the medical fitness for service of MHWTS respondents	56
Figure 2.9	FWS participating family members, by relationship to Current Serving MHWTS respondents	59
Figure 2.10	FWS participating family members, by relationship to Ex-Serving MHWTS respondents	60
Figure 3.1	Perceived effect of ADF members' military service on themselves, stratified by their military status as reported by family members	98
Figure 3.2	Perceived effect of FWS participants' own current or former military service on themselves, stratified by military status of ADF members	100
Figure 3.3	Perceived effect of ADF members' military service on civilian FWS participants, stratified by military status of ADF members	102
Figure 3.4	Perceived effect of ADF members' service on ADF members, stratified by military status of ADF member	121
Figure 3.5	Perceived effect of ADF members' service on civilian spouses/partners, stratified by military status of ADF member	122
Figure 3.6	Perceived effect of spouses'/partners' own ADF military service on their wellbeing, stratified by military status of ADF member	123
Figure 3.7	Perceived effect of ADF members' service on ADF members (adult children perspectives), stratified by military status of ADF member	152
Figure 3.8	Perceived effect of ADF members' service on their adult children, stratified by military status of ADF member	153
Figure 3.9	Parent perceptions of the effect of ADF members' service on ADF members, stratified by military status of ADF member	163
Figure 3.10	Perceived effect of ADF members' service on parents, stratified by military status of ADF member	165

Acknowledgements

Study participants

First and foremost, we acknowledge all current and ex-serving ADF personnel and their family members who generously gave their time to take part in the study. This research was only made possible by their efforts and commitment to the study. Other key contributors are listed below.

Principal investigator – Part 1

Dr Galina Daraganova, Senior Research Fellow, Executive Manager of Longitudinal and Lifecourse Studies, Australian Institute of Family Studies

Principal investigator – Part 2

Dr Stewart Muir, Senior Research Fellow, Manager of Policy and Service Systems, Australian Institute of Family Studies

Lead statistician – Part 1

Dr Helena Romaniuk, Research Fellow and Lead Statistician, Longitudinal and Lifecourse Studies, Australian Institute of Family Studies

Investigators – Part 1

Dr Diana Smart, Senior Research Fellow, Longitudinal and Lifecourse Studies, Australian Institute of Family Studies

Dr Stephanie Hodson, National Manager, Veterans and Veterans Families Counselling Service, Department of Veterans' Affairs

COL Nicole Sadler (Reservist), Senior Specialist, Military and High Risk Organisations, Phoenix Australia – Centre for Posttraumatic Mental Health, University of Melbourne

Ms Helen Benassi, Mental Health, Rehabilitation and Psychology Branch, Joint Health Command, Department of Defence; PhD candidate, Australian National University

Australian Institute of Family Studies

Part 1: Dr Jacqui Harvey, Ms Kelly Hand, Dr Sarah Gray, Ms Michelle Silbert, Dr Ben Edwards¹

Part 2: Dr Jacqui Harvey, Mr Sam Morley, Dr Galina Daraganova, Dr Helena Romaniuk, Dr Diana Warren, Ms Kelly Hand

AIFS communications and publishing staff

Centre for Traumatic Stress Studies, University of Adelaide

Dr Miranda Van Hooff, Dr Ellie Lawrence-Wood, Professor Alexander McFarlane, Dr Craig Hansen, Dr Blair Grace, Mr Roger Glenny, Ms Maria Abraham, Ms Jenelle Baur, Ms Ashleigh Kenny, Ms Marie Iannos, Dr Jodie Avery, Dr Amelia Searle, Dr Elizabeth Saccone, Ms Jane Cocks, Mr Jeremy Hamlin, Ms Judy Bament, Ms Dianne Stewart

Transition and Wellbeing Research Programme Scientific Advisory Committee

RADM Jenny Firman (co-chair), Dr Ian Gardner (co-chair), Professor Ian Hickie, Professor Malcolm Battersby, Professor Mark Creamer, Professor Peter Butterworth, Professor Lyndall Strazdins, Dr Paul Jelfs, Dr Duncan Wallace, GPCAPT Lisa Jackson Pulver, Professor Tim Driscoll, Professor Kathy Griffiths, Professor Beverley Raphael, Dr Graeme Killer

Transition and Wellbeing Research Programme Management Team

Department of Veterans' Affairs: Ms Kyleigh Heggie, Ms Karen Barker, Dr Loretta Poerio, Ms Melissa Preston, Dr Carmel Anderson, Ms Mary-Ann Fisher

Department of Defence: COL Laura Sinclair, Ms Jess Styles, Ms Kanny Tait, Mr Zushan Hashmi

For their assistance in developing the **Military and Veteran Research Study Roll**: Mr Mark Watson and Ms Megan MacDonald, Department of Veterans' Affairs, and Ms Carolina Casetta and Warrant Officer Class One Iain Lewington, Joint Health Command, Department of Defence

Other key organisations

ARTD Consultants for survey collection

¹ Currently, Associate Professor Ben Edwards, Centre for Social Research and Methods, The Australian National University.

PART 1
Families of Current and Ex-Serving ADF
Members: Health and Wellbeing

Executive summary

Family Wellbeing Study overview

The Family Wellbeing Study forms part of the Transition and Wellbeing Research Programme being undertaken for the Department of Defence and the Department of Veterans' Affairs. The Programme contains three related studies: the Mental Health and Wellbeing Transition Study (MHWTS), the Impact of Combat Study and the Family Wellbeing Study (FWS). The first two studies are led by the Centre for Traumatic Stress Studies at the University of Adelaide, and the third is led by the Australian Institute of Family Studies.

The FWS was designed to investigate the health and wellbeing of families of current serving and ex-serving Australian Defence Force (ADF) members, and the impact of military service on families. The ADF members were either in full-time active ADF service in 2015 or had left ADF service between 2010 and 2014. The FWS has two parts: *Part 1: Families of Current and Ex-Serving ADF Members: Health and Wellbeing* is a quantitative component for which information covering many areas of life was collected using structured online surveys; and *Part 2: Military Family Approaches to Managing Transition to Civilian Life*, a quantitative component that investigates the support military families give ADF members following exit from service, and ways in which families themselves can be better supported, using insights gained during semi-structured telephone interviews.

Part 1 examines the following five questions:

- What is the overall health and wellbeing of Australian military families (e.g. their mental health, physical health, couple relationships, family financial wellbeing)?
- Do families of current serving and ex-serving ADF members differ on these characteristics? Do they experience similar or unique problems?
- What is the effect of military service on families?
- What are the help-seeking needs of military families? Do needs differ for families of current serving and ex-serving ADF members?
- Do ADF members' service characteristics and personal functioning affect the health and wellbeing of FWS families after taking into account other salient factors?

Methodology

The FWS sample was identified during the data collection for the MHWTS. Current serving and ex-serving ADF members (referred to as 'ADF members' from now on) were asked during their interview to provide names and contact details for up to three family members who could then be invited to take part in the FWS. They were also asked to give permission for their MHWTS data to be linked to family members' FWS data and to tell nominated family members that the Australian Institute of Family Studies would be in touch to invite participation in the FWS.

A total of 1,387 family members provided the information used in Part 1 of this report. Three main subgroups took part: 983 were spouses/partners (69%; 677 were spouses/partners of Current Serving and 306 of Ex-Serving ADF members); 275 were parents (20%; 182 were parents of Current Serving and 93 of Ex-Serving ADF members); and 102 were adult children (7%; 54 were adult children of Current Serving and 48 of Ex-Serving ADF members). While a slightly larger number of family members had initially participated, a small number were later excluded for various reasons, such as high levels of missing data (see Chapter 2 for details).

Analyses revealed that the ADF members whose family members participated in the FWS were not completely representative of the wider Programme population from which they were derived. Thus, they tended to be older, more highly educated, contain a higher proportion of females, and hold more senior ranks (although the full range of ADF member characteristics was covered). Additionally, the Army was slightly under-represented, while the Air Force was over-represented. If these characteristics are associated with better functioning, which then influences the health and economic wellbeing of military families, caution may be needed when generalising the FWS findings beyond the current sample. This should be borne in mind when considering the FWS findings.

Key findings

How are Australian military families faring?

Residential and school mobility

Residential relocations were a relatively common experience for FWS families. Only 15.3% had never moved because of their ADF members' military service, while 22.1% had moved one to two times, and 62.6% had moved three or more times. School-age children had moved primary or secondary schools from one to six times, with 19.8% having attended three schools and 37.5% four or more schools. Family and school moves had occurred considerably more often than in the general Australian population. Relocations are an unavoidable part of the military family lifestyle and can place strain on individual and family wellbeing, employment and careers, and social

networks. The FWS findings are in line with much other Australian and international research on this issue.

Financial wellbeing and employment

Most FWS families seemed to be financially secure, although a slightly higher percentage had experienced one or more financial hardships than in other Australian general community studies. Two in three spouses/partners were working at the time of the FWS, and of those who were working, 60.5% were full-time and 39.5% were part-time. Some negative effects of a military family lifestyle on spouses'/partners' employment and careers were evident, with just over half feeling their careers had been negatively affected by their ADF members' military service. It seemed common for spouses/partners to feel they had made career sacrifices to support their ADF members' military careers.

Family wellbeing

Most FWS families seemed to be functioning well. For example, 78.6% of spouses/partners reported being happy in their couple relationship and a great majority were very positive about the differing features of relationships examined. Even more ADF members reported being satisfied with their couple relationship (82.5%). Nevertheless, these rates are slightly lower than in some other general community studies, although were high overall. The prevalence of abuse at some stage of couple relationships was very low (4.8%) and slightly lower than the Australian general population rate (6.6%), indicating that FWS couples did not experience abuse in their couple relationships more often than civilian couples. When asked about their parenting practices, most spouses/partners reported high levels of warmth, consistency and use of reasoning and low levels of hostility (although this could, to a certain extent, reflect social desirability – a tendency to report positively about oneself). They also expressed high confidence in their parenting abilities.

Personal health and wellbeing

A small number of spouses/partners and parents reported being in poor physical health in the past 12 months (13.7% of spouses/partners, 8.4% of parents). Similar numbers had experienced mental health problems such as psychological distress in the last four weeks (16.8% and 14.4% respectively), posttraumatic stress disorder (PTSD) symptoms in the last four weeks (11.1% and 11.9% respectively) or suicidality in the past 12 months (thoughts, plans or attempts – 13.4% and 10.6% respectively). However, rates of psychological distress were higher among adult children (29.0%), and higher than the Australian general population of a similar age and sex. Adult children also reported higher rates of suicidality than the other respondent subgroups (18.0%). While around four in five children aged 2 to 17 years were not reported to have high levels of behaviour problems, rates of hyperactivity, emotional symptoms and peer problems were higher among children in families of Current Serving members

than in general community populations. Thus, there may have been a greater vulnerability to mental health problems among young adults generally and the 2- to 17-year-old children of Current Serving ADF members. Rates of problem drinking, illicit drug use, and gambling were similar to those found in the Australian general population for spouses/partners, parents and adult children, and in fact spouses/partners and parents reported slightly less illicit drug use and gambling by comparison with the general Australian population.

Were there differences between families of Current Serving and Ex-Serving ADF members?

Families of Current Serving and Ex-Serving ADF members were similar on many of the aspects examined. However, there were also some signs that spouses/partners of Ex-Serving ADF members were experiencing more difficulties. While couple relationships were generally very strong, spouses/partners of Ex-Serving ADF members were somewhat less positive about the quality of their couple relationship than those with Current Serving ADF members. Additionally, rates of abuse at some stage of couple relationships were significantly higher among spouses/partners with Ex-Serving than Current Serving ADF members (8% compared with 3%). Spouses/partners of Ex-Serving members had significantly more often reported some type of suicidality in the previous 12 months (thoughts, plans or attempts). Finally, they significantly more often reported problem drinking and illicit drug use in this time period than the spouses/partners of Current Serving ADF members, although not over the period of their lifetimes. However, they did not experience significantly more physical health problems or other types of mental health problems.

Families of Ex-Serving ADF members had also significantly more often experienced particular financial hardships in the past two years, such as not being able to pay the mortgage or rent on time, or needing to sell or pawn something, although they did not significantly differ on the total number of hardships experienced. Overall, these findings are consistent with other research suggesting that the period following exit from service can be a vulnerable time for families.

There were some specific difficulties for spouses/partners of Current Serving ADF members as well. They significantly more often perceived that their employment and careers had been negatively affected by their serving members' military careers, and their families had experienced significantly more residential moves or relocations, with these two characteristics likely to be related. Both factors can be a source of stress for families. There were also some indications that 2- to 17-year-old children of Current Serving ADF members were exhibiting more problem behaviours than children of Ex-Serving ADF members.

Parents and the adult children of ADF members did not seem to be affected by whether their family members were Current Serving or Ex-Serving. Thus, effects of transition from military service seem to mainly be experienced by spouses/partners and their immediate family.

What is the effect of military service on military families?

ADF members' military service was perceived to have both positive and negative effects on family members, and sometimes no effect at all. Areas in which positive effects predominated were: (a) relationships with immediate and wider family members, and (b) the financial situation of spouses/partners. Areas in which negative effects predominated were mental health, employment and careers for spouses/partners. Areas in which the majority reported no effects were: (a) physical health for all FWS subgroups, and (b) mental health, employment, careers and financial situation for the parents and adult children of ADF members.

Thus, the effects of military service were differentiated both by the areas of life examined, and FWS participants' relationship to their ADF members. Of most concern were the perceived negative effects on all subgroups' mental health, and on spouses'/partners' employment and careers. On the positive side, family relationships were often perceived to be strengthened or not affected by ADF members' military service. Thus, effects of military service on family members appeared complex and nuanced.

What are the help-seeking needs of military families?

Of the 54.4% of spouses/partners who had been concerned about their own mental health, 86.6% knew where to obtain help, and 79.5% had sought help. Findings were similar for parents. There were no significant differences between those whose ADF members were Current Serving or Ex-Serving on their need for services, knowledge about where to obtain help, and rates of service use. Given that the great majority of FWS participants knew where to obtain help and had done so, there did not seem to be a substantial unmet need for mental health services among FWS family members, although their satisfaction with the services received is not known. However, these results could, to a certain extent, reflect the relatively well-educated nature of the FWS sample, as they may have greater knowledge of the resources available, or capacity to obtain assistance. It is possible that less advantaged military family samples may exhibit higher levels of unmet need. There may also have been an unmet need for other types of services beyond mental health services (e.g. for family or child problems), as this was not examined by the FWS.

When asked whether they had experienced barriers to service use, 76.5% of those who had not accessed mental health services said they preferred to handle problems independently, with only a minority reporting barriers such as cost (22.4%), or stigma

arising from service use (33.7%). The reasons for not seeking help for mental health problems therefore seemed more internally than externally motivated.

Do ADF members' service characteristics and personal wellbeing affect FWS families after taking into account other salient factors?

Multivariate modelling was used to investigate the factors that were significantly related to FWS family members' health and wellbeing after the effects of other salient influences were taken into account.

FWS family members' psychological distress had the most widespread impact, either by itself or when combined with poor physical health. These difficulties were related to all three outcome types: couple relationships, parenting practices and child behaviour problems. Additionally, FWS family members' poor physical health by itself was related to several problem outcomes.

ADF members' mental and/or physical health problems were also significant influences, but not as consistently as those of FWS participants. The other FWS personal characteristics examined (highest level of educational achievement; unemployment) were generally not significantly related to outcomes.

Several service-related characteristics were also important after controlling for the effects of other factors. If ADF members held higher ranks or had a longer service history, their family members' mental health outcomes tended to be more positive and couple relationships tended to be stronger. However, the other aspects of ADF members' service history examined (whether current serving or ex-serving; service type; deployment; being physically unfit for service) were generally not significantly related to outcomes. Whether FWS participants themselves had served in the ADF was also a significant influence, with serving spouses/partners being more vulnerable to psychological distress and PTSD and lower on parenting warmth than civilian spouses/partners.

Only one family characteristic was related to multiple outcomes after controlling for the effects of other factors. This was being the adult child of one's ADF member, with the adult children subgroup found to be more vulnerable to mental health problems and risky drinking than the spouse/partner and parent subgroups. This is consistent with earlier comparisons to general population data, which revealed higher levels of psychological distress in the adult children subgroup by comparison with the civilian population of a similar age and sex. The other family factors examined – whether couples had biological children together, a larger household size, and parenting practices – were related to single outcomes only and did not seem to have a consistent effect.

Overall, FWS family members' physical and mental health problems appeared the most salient influences, but ADF members' service rank and length of service were also important, particularly in the areas of family members' psychological wellbeing and couple relationships. Spouses/partners who had served in the ADF and the adult children of ADF members were also more vulnerable to mental health problems than the other groups to which they were compared.

Conclusions and implications

The FWS has provided many valuable insights into the physical, psychosocial and economic wellbeing of Australian military families. While it yields a generally positive picture, it has also identified particular subgroups – adult children, children aged 2 to 17 years, spouses/partners of Ex-Serving ADF members, and spouses/partners who have served in the ADF – who seem to be encountering more challenges and may benefit from targeted support and assistance.

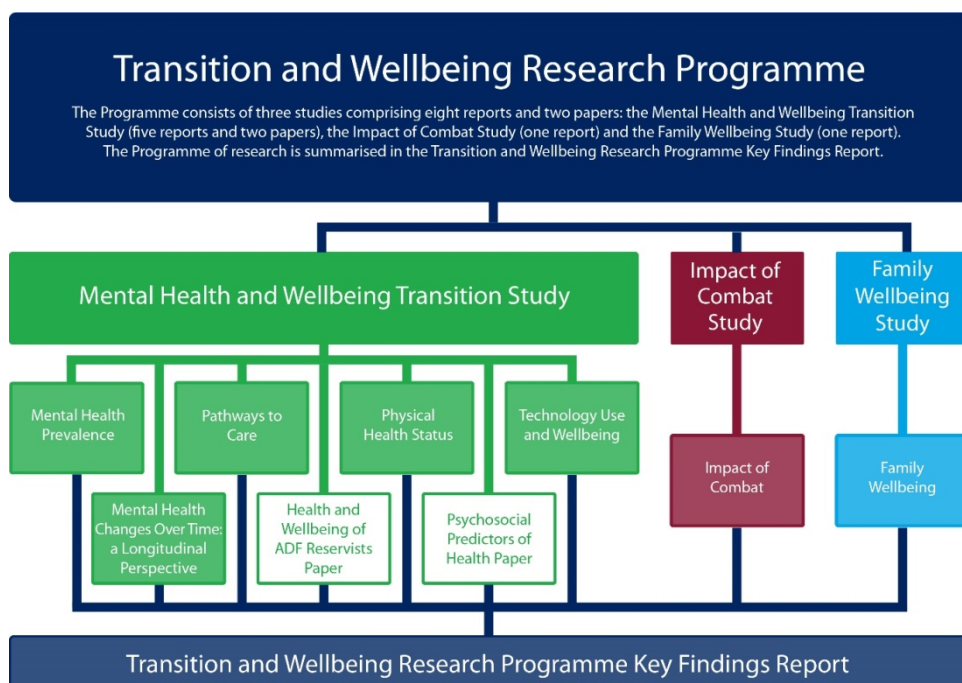
1 Introduction

1.1 Transition and Wellbeing Research Programme – an overview

The Transition and Wellbeing Research Programme (Programme) (Figure 1.1) is the most comprehensive study undertaken in Australia that examines the impact of military service on the mental, physical and social health of:

- serving and ex-serving Australian Defence Force (ADF) members, including those who have been deployed in contemporary conflicts
- their families.

Figure 1.1 Transition and Wellbeing Research Programme overview



This research further extends and builds on the findings of the world-leading research conducted with current serving members of the ADF in the 2010 Military Health Outcomes Program.

This current research, conducted in 2015, arises from the collaborative partnership between the Department of Defence (Defence) and the Department of Veterans’

Affairs (DVA). Department of Defence (Defence). It aims to implement the Government's goal of ensuring that current and future policy, programs and services are responsive to the current and emerging health and wellbeing needs of serving and ex-serving ADF members and their families before, during and after transition from military life.

Ten objectives were developed to guide the Programme (Table 1.1). The objectives are being realised through three studies comprising eight reports: the Mental Health and Wellbeing Transition Study (five reports and two papers), the Impact of Combat Study (one report), the Family Wellbeing Study (one report consisting of quantitative and qualitative parts) and the Transition and Wellbeing Research Programme Key Findings report, which summarises the research.

This Family Wellbeing Study addresses the tenth research objective, which is to investigate the impact of ADF service on the health and wellbeing of families whose ADF members left the ADF between 2010 and 2014 (termed 'Ex-Serving' in this report) and of families whose ADF members were in full-time active service in 2015 (termed 'Current Serving' in this report).

Table 1.1 Transition and Wellbeing Research Programme objectives and Studies and reports

Programme objectives	Corresponding reports and papers
1. Determine the prevalence of mental disorders among ADF members who have transitioned from Regular ADF service between 2010 and 2014.	<i>Mental Health Prevalence Report</i>
2. Examine self-reported mental health status of Transitioned ADF and the 2015 Regular ADF.	
3. Assess pathways to care for Transitioned ADF and the 2015 Regular ADF, including those with a probable 30-day mental disorder.	<i>Pathways to Care Report</i>
4. Examine the physical health status of Transitioned ADF and the 2015 Regular ADF.	<i>Physical Health Status Report</i>
5. Investigate technology and its utility for health and mental health programmes, including implications for future health service delivery.	<i>Technology Use and Wellbeing Report</i>
6. Conduct predictive modelling of the trajectory of mental health symptoms/disorders of Transitioned ADF and the 2015 Regular ADF, removing the need to rely on estimated rates.	<i>Mental Health Changes Over Time: a Longitudinal Perspective Report</i>
7. Investigate the mental health and wellbeing of currently serving 2015 Ab-initio Reservists.	<i>The Health and Wellbeing of ADF Reservists Paper</i>
8. Examine the factors that contribute to the wellbeing of Transitioned ADF and the 2015 Regular ADF.	<i>Psychosocial Predictors of Health Paper</i>
9. Follow up on the mental, physical and neurocognitive health and wellbeing of participants who deployed to the Middle East Area of Operations between 2010 and 2012.	<i>Impact of Combat Report</i>
10. Investigate the impact of ADF service on the health and wellbeing of the families of Transitioned ADF and the 2015 Regular ADF.	<i>Family Wellbeing Study</i>
All objectives	<i>Transition and Wellbeing Research Programme Key Findings Report</i>

Two eminent Australian research institutions, one specialising in trauma and the other in families, are leading the research programme. The Centre for Traumatic Stress Studies at the University of Adelaide is conducting the Mental Health and Wellbeing Transition Study and the Impact of Combat Study, and the Australian Institute of Family Studies is conducting the Family Wellbeing Study.

Their research expertise is enhanced through partner institutions from Monash University, the University of New South Wales, Phoenix Australia – Centre for Posttraumatic Mental Health and, until June 2016, the Young and Well Cooperative Research Centre, the work of which is being continued through the University of Sydney.

Through surveys and interviews, the researchers engaged with a range of DVA clients and ADF members, including:

- ADF members who transitioned from the Regular ADF between 2010 and 2014 (including ex-serving, Active and Inactive Reservists)
- a random sample of Regular ADF members serving in 2015
- a sample of Ab-initio Reservists serving in 2015 (who have never been full-time ADF members)
- 2015 Regular ADF and Transitioned ADF members who participated in the Military Health Outcomes Program
- family members nominated by the above.

1.2 Family Wellbeing Study

The Family Wellbeing Study was initiated by the Department of Defence and DVA due to a lack of knowledge about the health and wellbeing of contemporary families of current serving and ex-serving ADF members. It aimed to increase understanding of the challenges and opportunities military families face during and following military service through two separate but related studies:

- **Family Wellbeing Study: Part 1: Families of Current and Ex-Serving ADF Members: Health and Wellbeing.** The main objectives of Part 1 were to provide a quantitative investigation of the mental, physical, social and financial wellbeing and circumstances of military families of current serving and ex-serving ADF members; their military-related experiences and impact; and their service needs and access. An online survey of military families was used to collect the study data. The study makes use of survey data provided by family members who participated in the FWS Part 1 and data from Current Serving and Ex-Serving ADF members collected

in the Mental Health and Wellbeing Transition Study (MHWTS) and the Impact of Combat Study (Van Hooff et al., 2018).

- **Family Wellbeing Study: Part 2: Military Family Approaches to Managing Transition to Civilian Life.** Part 2 aimed to increase understanding of how Australian families support ADF members' transition from ADF service to civilian life through an in-depth investigation of the experiences of 25 adult family members of Ex-Serving ADF members. This was an exploratory qualitative study in which semi-structured telephone interviews were conducted. The study aimed to shed light on ways in which families can more effectively support transitioning ADF members and how families themselves can be better supported (Muir, 2018).

1.2.1 Structure of Part 1

Part 1 of the Family Wellbeing Study consists of five chapters:

Chapter 1 provides an overview of the Transition and Wellbeing Research Programme and the background to the FWS. It then discusses relevant Australian and international research to provide a context for the FWS and to identify key research gaps. Finally, the aims and objectives of the FWS are described.

Chapter 2 describes the methodology of the study, including study design, recruitment, nomination processes and response rates, samples obtained, and caveats around the sample representativeness. It also provides details of the measures used.

Chapter 3 describes the characteristics of participating family members as well as challenges and opportunities they may have encountered. Section 3.1, entitled 'Meet the families', describes characteristics of individuals who participated in the FWS and also examines whether there are significant differences between those whose ADF members were Current Serving or Ex-Serving. Section 3.2 (how FWS spouses/partners are faring) reports the perspectives, experiences and wellbeing of spouses/partners, while sections 3.3 (how adult children are faring) and 3.4 (how parents of ADF members are faring) look at similar issues for the adult offspring and parents of MHWTS participants (overall, and by whether ADF members were Current Serving or Ex-Serving).

Chapter 4 provides a more nuanced picture of the family and military factors that are related to military families' wellbeing. Multivariate modelling is used to identify the factors that are significantly related to a range of outcomes after the contribution of other influential factors is taken into account. This allows examination of the influence of military lifestyle factors within the context of other salient influences.

Chapter 5 brings the findings together to discuss the general trends emerging, and the learnings and implications that may be gained. Where possible, findings are compared to general population trends to evaluate how members of military families are faring.

1.3 Overview of knowledge about military families and their wellbeing

The supporting role played by families in the health and wellbeing of serving and ex-serving members is well acknowledged and understood. However, much less is known about the wellbeing of military family members themselves. The following literature review provides an overview of relevant Australian and international research to date on military families and their physical, mental, social and economic wellbeing. Starting by describing the role of military families, the review discusses challenges and opportunities families face during and following military service and the factors that make for a successful transition from military service to civilian life. This is followed by an overview of salient research in areas such as the variability of military families, housing and residential mobility; economic wellbeing, including employment and financial wellbeing; aspects of family wellbeing such as couple relationships and parenting; mental and physical health; risk-taking such as alcohol and illicit drug use; gambling; social support; and pathways to care.

A number of caveats to this literature review should be noted. First, the review highlights the most relevant findings and is indicative rather than comprehensive. Next, there is a lack of Australian information on many topics; hence, the review relies to a large extent on research from the United States, the United Kingdom and Canada, with its applicability to the Australian context being uncertain. Where Australian research exists, it is included in preference to international research. Third, there has been an understandable focus on serving members' circumstances and wellbeing, but there has been less research on how their families fare. Similarly, some topics have received much attention (e.g. mental health) but there has been little or no research in other areas (e.g. homelessness in military families). Our review reflects this selectivity. Finally, while the dimensions examined directly affect individual and family wellbeing, indirect effects are also probable through the impact of factors such as posttraumatic stress disorder on other influential factors such as family relationships or parenting capacities, which then influence outcomes. However, the research reviewed often investigates direct effects only. The possibility of indirect effects and the burden created by multiple problems should be borne in mind.

1.3.1 The importance of military families

Families can play important roles at all stages of an individual's service career. A common saying in the military is that when one person joins, the whole family serves. For instance, research shows that young members of military families are more likely

to join the military themselves compared with other young people (Stander & Merrill, 2000), perhaps reflecting a family's commitment to serving their country. Family attitudes can also greatly affect young people's enlistment decisions (Gibson, Griepentrog, & Marsh, 2007), with more positive family attitudes associated with higher rates of enlistment. When military members are serving, families can promote morale (Rosen, Moghadam, & Vaitkus, 1989) and support serving members' wellbeing, preparedness and capacity to carry out missions (Dursun & Sudom, 2009). Families can also powerfully influence serving members' decisions about whether to remain in the military, which in the long term can affect a country's defence force stability and preparedness. Australian research indicates that family members' perceptions that family life was suffering and the work commitments arising from military service were too high were key motivators of intentions to leave among ADF members (Atkins et al., 2014). Overall, families are crucial influences on the wellbeing and decision-making of serving members and any efforts to build a strong, effective and sustainable military force must also consider families, improving the relationships of soldiers with their family members and strengthening families themselves (Gottman, Gottman, & Atkins, 2011).

1.3.2 Families during military service

Most research on the health and wellbeing of family members during military service has focused on the impact of deployment during wartime. Overall, international research suggests that this is a period when family members are more at risk of negative psychosocial outcomes (Dursun & Sudom, 2009; Mansfield et al., 2010). Nevertheless, even during peacetime, military families can experience unique pressures. For example, the frequent moves that are part of the military family lifestyle create both challenges and opportunities. Family members may face separation from extended families, changes in child care and schools, disruption to social connections, loss of opportunities, and stress in adapting to new contexts (Burrell, Adams, Briley Durand, & Castro, 2006; Drummet, Coleman, & Cable, 2003). Military relocations can also provide opportunities to broaden social networks and increase self-confidence after successfully coping with their challenges (see the qualitative study of Runge, Waller, MacKenzie and McGuire, 2014). Moving can also create a financial burden and a loss of employment opportunities for spouses/partners of ADF members. This is but one example of the difficulties that can be experienced by military families during peacetime. Others include the family readjustments often needed post-deployment (Bowling & Sherman, 2008), long and often unpredictable duty hours (Huffman & Payne, 2006), and the threat of injury or death during routine training and peacekeeping missions (Dirkzwager, Bramsen, Ader, & Van Der Ploeg, 2005).

1.3.3 Families after military service

Military life can be difficult, demanding and dangerous. But the transition to civilian life can also be stressful and challenging for ex-serving members and their families. While there is no 'blueprint' for a successful transition, researchers have identified a number of adaptations across a range of areas that contribute to a smoother transition (Berle & Steel, 2015; Bowling & Sherman, 2008; Danish & Antonides, 2013; Huffman & Payne, 2006; Ray & Heaslip, 2011). Within-person adjustments can include re-forming one's identity; changes in self-esteem, self-efficacy and locus of control; a shift in one's sense of belonging; and modification of one's belief system, perception of one's purpose in life and sense of self (Danish & Antonides, 2013). Within-family adaptations include renegotiating family roles and responsibilities; re-establishing relationships with spouses/partners and children; overcoming parenting challenges; and managing strong emotions during family interactions (Berle & Steel, 2015; Bowling & Sherman, 2008). The transition also involves a career change, which may require the acquisition of new qualifications or skills (Black, Westwood, & Sorsdal, 2007; Sherman, Larsen, & Borden, 2015). The gaining of employment can be difficult, with many experiencing extended or repeated periods of unemployment, as well as a frequent drop in family finances and loss of morale during this time (Loughran, 2014; Tanielian & Jaycox, 2008). Fitting back into or establishing new social networks is often needed and can be difficult, with families being important facilitators and sources of support (Hachey, Sudom, Sweet, MacLean, & Van Til, 2016). Thus, the transition can involve challenges on many fronts.

International research shows that between 25% and 50% of ex-serving members find the transition difficult, although rates differ across studies (Black et al., 2007; Hachey et al., 2016; MacLean et al., 2014; Morin, 2011). A number of factors appear to influence the ease of transition. For example, Morin (2011) found that ex-serving US members who experienced emotional trauma while serving, had suffered a serious service-related physical injury, served in a combat zone, and/or had a comrade who was killed or injured, were more likely to find the transition difficult (after controlling for the effects of a range of other factors). Morin (2011) also found that ex-serving members who experienced an easier transition tended to have held higher ranks, clearly understood their missions while serving, and/or were university-educated (holding the effects of other factors constant). Mental health problems such as posttraumatic stress disorder (PTSD) and substance use disorders are associated with a more difficult transition (Sayer et al., 2011). On the other hand, positive personal characteristics, social support and community belonging all facilitate an easier adjustment for ex-serving members (Hachey et al., 2016). Wiens and Boss (2006) looked at the family factors associated with risk or resilience during the transition period. Flexibility about family roles, good coping skills, and the presence of external social and community supports all helped ease the transition, while if families did not have external supports, were young or newly established, or had other life stressors,

the transition was more difficult. However, there seems to be very little other research into the effects of the transition on military families.

In summary, while a large body of research has examined factors related to ex-serving members' adjustment to civilian life, there is a critical knowledge gap in understanding the health and wellbeing of their families during this transition.

1.3.4 Composition of military families

There are no population-wide data on families of current serving and ex-serving ADF members. While basic family demographics of current serving members and reservists can be extracted from the Defence Census surveys or the ADF Families surveys (2008, 2012 or 2015), there are no equivalent surveys for families of ex-serving ADF members. However, some information on the family composition of current serving ADF members can be derived from the above data sources. The 2015 Defence Census Fact Sheet 5 (Department of Defence, 2015) shows that the majority were in a couple relationship of some kind. Thus, 40% were married and 24% were in an interdependent relationship. A small percentage were separated or divorced (4%), and 30% were single. A total of 39% had one or more dependent children, defined as an individual who is financially dependent on the service member and either 21 years or younger, a full-time student aged 25 years or younger, or a person with a disability. Only 5% had other types of dependants living with them, such as parents, grandparents or other relatives. These data suggest that current serving ADF members are living in a variety of family types, ranging from a 'nuclear' family (a couple with children), to a single-person household or living with one's biological family. Thus, military families can vary greatly in composition and the types of family members they include. However, the research conducted to date on military families focuses almost exclusively on those in a 'nuclear' family situation.

There seems to be very little research on other types of military family members, for example the siblings or parents of current serving or ex-serving members. We next look at findings from the few studies located. One very small, exploratory US study used focus groups and surveys of extended family members to investigate the effects of deployment on them (Demers, 2009). The types of family members participating in the study were wives/partners, mothers/fathers, siblings, and uncles/cousins. Most reported being negatively affected by deployment, with high levels of psychological and relationship distress evident. Participants expressed a need for social and emotional support that had been largely unmet. Crow, Myers, Ellor, Dolan, and Morissette (2016) investigated the effect on US parents of the deployment of their adult child and found that as well as being concerned about their child's possible loss of life, parents worried that their child would be personally changed by the experience (Crow et al., 2016). Other concerns expressed were how their adult child would fit back into the family and whether the relationship with their child would be affected.

Another small, exploratory US study investigated ex-serving members' experiences living with their birth families after their transition from military service (Worthen, Moos, & Ahern, 2012). While the emotional and material support provided by parents was appreciated, some also experienced conflict and strain, particularly around ex-serving members' new adult status where either too much was expected of them or their maturity was not well recognised. Importantly, when ex-serving members had difficulty in making the transition to civilian life or had mental health problems, parents were often the first to notice and help their sons/daughters to access care.

The 2014 US Military Family Lifestyle Survey (Bradbard et al., 2014) contained a small group of parents of serving members (5%). The main aim of including parents was to assess how connected they felt towards aspects of military life. Overall, three-quarters of parents felt 'very connected' to their serving sons/daughters and to other parents of serving members. However, fewer felt connected to the general military community and only about one-third to the unit in which their offspring was serving. Anecdotal feedback suggested that a number of parents felt disempowered and disconnected; for example, one said 'we have no rights as parents, we are not acknowledged even when our child is single and we are his next of kin', while another said 'I felt like no one understood [what it was like] going through the anxiety of his deployment ... everything was geared to support only spouses'. However, the Australian experience may differ; for example, the 2015 ADF Families Survey found that parents were generally well informed about their sons'/daughters' deployment, with 72% knowing how to communicate with their child while he/she was deployed and 66% knowing how to seek information about the deployment (Brown, Wensing, & Department of Defence, 2016).

These family members can be an important source of support for current serving and ex-serving members and their immediate families (e.g. spouses/partners, dependent children). More attention to the wellbeing and contribution of this subpopulation is needed. Given that the FWS includes parents and adult offspring of current serving and ex-serving ADF members, it will be able to shed valuable new light on the role and welfare of these other family members. However, as the focus of previous research has been on military families with spouses/partners with or without children, our literature review focuses on these family types only (recognising that there are other family configurations that may play differing roles and make unique contributions to the wellbeing of current serving and ex-serving ADF members and their families).

1.3.5 Housing and residential mobility

Housing

Military families reside in a variety of housing arrangements, largely reflecting whether they are located on or away from a military base, and whether or not their housing is

financially supported or provided by governments. The Australian 2012 ADF Families Survey (Atkins et al., 2014) reported that almost half of the families in their study lived in off-base accommodation supplied by the ADF, around 30% were purchasing their own home, one-tenth were renting a private dwelling with rent assistance from the ADF, and the remainder were in other situations (e.g. living in barracks, living on base, privately renting without rent assistance, or owning their own homes).

There appears to be little research examining the effects of differing living arrangements on military families, although Chandra and colleagues (2010) found that US children whose families were living on base experienced fewer difficulties during their parents' deployment than those living in rented accommodation. However, their study was unable to shed light on the reasons underlying these findings. It would seem valuable for future research to investigate whether differing living arrangements affect families' day-to-day, economic, social or psychological wellbeing.

Homelessness among ex-serving members has been highlighted as an important and growing issue (Commonwealth of Australia, 2016). Australian research on this issue appears limited, although the Australian MHWTS reported that 4.4% of Ex-Serving ADF members had not been in stable housing in the previous two months (Van Hooff et al., 2018). There are also anecdotal reports indicating that the numbers of ex-serving members experiencing homelessness during a calendar year range from 300 to 3,000, depending on how ex-serving status and homelessness are defined (Commonwealth of Australia, 2016). US research suggests a lifetime rate of homelessness among ex-serving members of 8.5% (Tsai, Link, Rosenheck, & Pietrzak, 2016). A meta-analysis of US research has shown that the most powerful risk factors for homelessness among ex-serving members were substance use disorders, mental illness, and low income (Tsai & Rosenheck, 2015), with social isolation, a more difficult childhood, and past incarceration also contributing. Additionally, another recent meta-analysis suggested that homeless was more common among female ex-service members than their male counterparts (Byrne, Montgomery, & Dichter, 2013), with factors increasing the risk of homelessness among female ex-serving members including sexual assault during service, unemployment, being disabled, poorer health, and mental health problems such as PTSD or anxiety (Washington et al., 2010). Conversely, being married or having a university education were found to be protective.

While there has been considerable research on homelessness among ex-serving members, information on homelessness in military families is lacking and constitutes a clear gap in knowledge about the wellbeing of military families.

Residential mobility

The high number and negative impact of service relocations experienced by military families have been widely researched (Drummet et al., 2003; Park, 2011; Sheppard,

Malatras, & Israel, 2010). In the Australian context, the 2015 ADF Families Survey (Brown et al., 2016) found that 87% of families in their study had relocated at least once during the serving member's military career. The most frequent number of moves experienced for service reasons was 1 to 3 times (42%), while 24% had moved 4 to 6 times, 10% had moved 7 to 9 times and 11% had moved 10 or more times. When asked about the impact of these moves on families, gaining employment for spouses/partners had been the most common difficulty (56%), followed by re-establishing support networks (53%), access to services needed by families (52%), arranging child care (50%) and after-school care (47%), spouses'/partners' educational requirements (42%), and adjusting to new secondary schools or re-establishing older children's friendships and activities (42%). The earlier 2012 ADF Families Survey² found that a greater number of service-related moves was related to higher levels of difficulty in re-establishing family life (Atkins et al., 2014). Additionally, the 2012 ADF Families Survey reported that families containing an ADF member and a civilian spouse or partner seemed to experience more difficulties than other military family types, as did military families with children who had special needs. International research also shows negative effects of relocation over a wide range of aspects of family life (Burrell et al., 2006; Drummet et al., 2003). These findings suggest that the frequent relocations associated with military service can have a cumulative negative impact on military families over a wide range of areas, including psychological and social wellbeing, employment, education and access to services. While positive benefits can ensue from service relocations, such as the development of larger social networks within and outside one's country, enhanced skills in adapting to new conditions, building social networks, managing access to service, better stress management skills and abilities to deal with ambiguities, the research to date has focused on and highlighted the negative effects of service relocations on families.

1.3.6 Economic wellbeing and employment

Financial wellbeing

There appears to be little Australian research on the financial wellbeing of Australian military families. However, US research suggests that serving members generally earn more than civilians with comparable levels of education (Hosek & Wadsworth, 2013). Their families also receive other benefits such as housing allowances, subsidised child care, financial assistance with children's tuition, and low-cost, high-quality health care. However, counterbalancing this positive picture, spouses/partners in US military families are more often unemployed or working fewer hours than their civilian counterparts and also tend to earn less (Hosek & Wadsworth, 2013). This is thought to result from the frequent residential moves experienced by military families, which can

² As the 2015 and 2012 ADF Families surveys contain different sets of information, both sources are referred to here.

cause career disruptions or deter employers from offering positions that involve skills training or a long-term investment in their staff (Harrell, Lim, Castaneda, & Golinelli, 2004). Deployments can also affect spouses'/partners' employment, with many needing to stop working or reduce the number of hours worked to care for children and households (Murphey, Darling-Churchill, & Chrisler, 2011). Hence, while additional allowances are provided during deployment, there may be a loss of income for families from spouses'/partners' wages.

Some military families experience financial hardship, with younger serving members in junior ranks who have large families being especially vulnerable (Hosek & Wadsworth, 2013). Approximately one-quarter of US military families encountered financial difficulties in 2010; for example, they experienced problems paying bills, issued cheques that bounced, missed making credit card payments, fell behind on rent or mortgage, were pursued by debt collectors for unpaid bills, and/or had essential services cut off (Hosek & Wadsworth, 2013). There can also be a substantial drop in earnings when ex-serving members move from military to civilian employment, with this especially an issue for those with a longer service record (Hosek & Wadsworth, 2013), mental health problems, or traumatic brain injuries, according to US research (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012). Australian research on the economic wellbeing of military families appears lacking and is an issue that the FWS would be well placed to address.

Employment

Military families can experience unique employment challenges, such as the impact of residential relocations and deployments on the careers of spouses/partners. Additionally, the nature of military service may magnify common employment issues experienced in the general community, for example achieving a satisfactory work-life balance; or navigating career direction changes or unemployment in the transition from military to civilian life. Research on these issues is next reviewed.

Australian and international research both confirm that spouses/partners make large career sacrifices to support their serving members' military career. For example, the 2012 ADF Families Survey found that three-quarters of spouses/partners felt their careers had been negatively affected by the military lifestyle. This was particularly an issue for those who were civilians rather than ADF members, or if their family's serving ADF members held more senior positions (Atkins et al., 2014). Similarly, the Canadian Perstempo Survey of military spouses reported that close to 40% felt they had made career sacrifices or that their careers had been negatively affected by their serving partners' careers (Dursun & Sudom, 2009). The Canadian Ombudsman's special report on the wellbeing of Canadian military families highlighted the significant difficulties spouses experienced in finding and retaining appropriate and ongoing employment, which was exacerbated when they were posted to smaller communities (Daigle, 2013).

Similarly, the US 2015 Military Family Lifestyle Survey (Orr Shiffer & Maury, 2015) found 75% of spouses who were working felt that the military lifestyle had impacted negatively on their ability to pursue a career, and all types of respondents (current serving members, ex-serving members or spouses) felt that spouse employment was one of the top three obstacles to family financial security. Additionally, if spouses were financially insecure, they were less likely to support their partners remaining in military service, a trend also noted by Daigle (2013). Thus, it is clear that spouses'/partners' employment opportunities and career development are key challenges for military families.

Achieving a satisfactory work–life balance appears to be another concern for military families. For example, the Australian 2012 ADF Families Survey (Atkins et al., 2014) found that 60% of respondents felt work demands had interfered with their home and family life, and close to half felt that work commitments had caused their family life to suffer or made it difficult to carry out family responsibilities. Moreover, these rates had increased since the previous survey, completed in 2008. Families in which both parents were in the ADF were more likely to experience work – family life balance problems, as were serving members who were single parents. To gain a sense of how these trends compare with the general Australian community, the findings from the 2012 Australian Work and Life Index (AWLI) were examined (Skinner, Hutchinson, & Pocock, 2012). Although the aspects measured were not identical, around one-third of AWLI respondents working full-time 'often or almost always' felt that work had restricted their time with family or friends, and a further 30% felt this had 'sometimes' occurred. Additionally, 22% were 'not satisfied' with their work–life balance. This comparison suggests that balancing work and family life may be more of a challenge for military than civilian families.

On the other hand, job security, which can be an important influence on the quality of family life (Kalil, Haskins, & Chesters, 2012), may be higher in military families than in the general community. The Australian 2012 ADF Families Survey (Atkins et al., 2014) found that of the military families who thought this issue was important, 69% were satisfied with and valued the job security provided by the ADF. While the available general population data uses slightly different questions, one survey of 23,548 employed Australians over the period 2013 to 2015 reported that 17% perceived their job security to be 'very good' and another 34% viewed it as 'good' (Roy Morgan, 2016). Thus, perceptions of job security may be higher in the ADF than in the general community.

Ex-serving members frequently experience unemployment or underemployment during their transition to civilian life. As an example, the recent Australian MHWTS found that at the time of survey, 29.6% of Ex-Serving members were unemployed (Van Hooff et al., 2018), although they were in a variety of circumstances, with 3.1% doing

unpaid work, 5.2% looking for work, 8.9% unemployed and receiving a sickness allowance or disability support pension, 6.9% studying, and 5.5% retired. The length of time since Ex-Serving members had left the ADF ranged from zero to five years, with the average being two and a half years. Hence, these statistics do not reflect the immediate post-service period for many. Further, of those who were not currently employed, 43.7% had experienced one or more episodes of being unemployed for three or more months.

It has also been reported that 19% of ex-serving ADF members are underemployed and not working in jobs that are commensurate with their skills, compared with 8.5% of the Australian employed population (WithYouWithMe, 2017). Higher rates of unemployment among military ex-serving cohorts than non-military populations are also found internationally (e.g. Loughran, 2014), although are strongest for younger ex-serving members, with rates decreasing among older ex-serving members and the lapse of time since transition. There can be problems with gaining steady employment as well (Tanielian & Jaycox, 2008). It is well established that unemployment has negative impacts on individuals and their families (Artazcoz, Benach, Borrell, & Cortès, 2004; Baxter, Gray, Hand, & Hayes, 2013; Bubonya, Cobb-Clark, & Wooden, 2014); hence, the much higher rates of unemployment among ex-serving members than others in the general community are concerning. Factors found to be related to unemployment among ex-serving members include deployment, exposure to combat (Loughran & Klerman, 2008; MacLean, 2010), and mental health problems, especially PTSD (Riviere, Kendall-Robbins, McGurk, Castro, & Hoge, 2011). However, while research clearly shows that unemployment can be a large issue for ex-serving members, there appears to have been little research on its consequences for their families. This is a large research gap that it will be important to address.

1.3.7 Family wellbeing

The wellbeing of the military family as a whole has been the focus of much research, with a range of issues examined. One of these is the unique challenges that military families experience. As outlined by Ender (2006), these include cyclical patterns of separation and reunification, which can require the taking on and giving up of new roles and responsibilities by at-home family members; frequent and often unexpected geographic moves that are estimated to occur every two to three years (Clever & Segal, 2013) and can disrupt parental employment, children's schooling, and child and parental social networks; particular constraints if the family is living on a military base (e.g. expectations about dress, behaviour, upkeep of property, attendance of activities); and the ongoing threat to the life and wellbeing of a deployed parent, which can be a source of stress and mental health problems for family members back home. Particular types of military families may be more prone to difficulties, especially those with pre-existing family problems; younger or less educated parents; lower incomes;

very young children or children with disabilities; or single-parent families (American Psychological Association Presidential Task Force, 2007).

However, Karney, Loughran and Pollard (2012), using data for the US population of active serving members from 1996 to 2005, showed that current serving members were significantly more likely to be married than a matched civilian cohort and were no more likely to be divorced (Karney et al., 2012). These findings suggest that military families tend to be resilient to the pressures of the military lifestyle (Park, 2011; Sheppard et al., 2010).

Three main areas of family wellbeing are believed to promote resilience in military families, as outlined by Meadows et al. (2015) and Wright, Riviere, Merrill and Cabrera (2013). Much of the research in this area has been conducted in the United States.

The first is the **family belief system**, including (a) the capacity to interpret and make sense of adversity; (b) an optimistic outlook, sense of control, positivity and confidence that the family can handle whatever comes their way; and (c) spirituality, a set of beliefs that provide meaning and faith. As examples, two-thirds of US spouses felt that their understanding of the worth and need for their partners' mission contributed to their own capacity to cope with the deployment (Defence Manpower Data Center, 2009), while another US study found that those who perceived their partners' military service to be valuable and meaningful were more likely to be satisfied with their marriage (Bergman, Renshaw, Allen, Markman, & Stanley, 2014). Australian research suggests that military families are generally doing well in these areas, with around three-quarters of respondents in the Australian 2012 ADF Families Survey being satisfied or very satisfied with their capacity to deal with stress, about two-thirds having positive perceptions of their ability to deal with situations they might encounter, and six-tenths being satisfied or very satisfied that their families were able meet the challenges of ADF life (Atkins et al., 2014).

The second area is **family organisational strengths**, including (a) being flexible and open to change, sharing activities, and spending time together; (b) having family traditions, routines and rituals; and (c) effective parenting practices. For instance, spouses who successfully managed the routine of running a household while their partners were deployed reported higher marital quality and satisfaction post-deployment (Pittman, Kerpelman, & McFadyen, 2004).

The third area is **family communication**, which includes (a) being clear, open and respectful; (b) the capacity for family members to work together to solve issues or problems; and (c) social support from extended families, friends and communities. For example, the quality of family communication during deployment was related to caregiver and child wellbeing, as well as fewer household and parenting problems during this time period (Chandra et al., 2011). Some also note that being part of the

military culture and ‘family’ may play an important role in fostering resilience (Park, 2011).

The Australian Timor-Leste Family Study supports this positive view of military family wellbeing (McGuire et al., 2012). The ratings of more than nine-tenths of spouses/partners of recently deployed service members were in the healthy range on family cohesion and flexibility; close to two-thirds reported family communication to be high or very high; and a similar percentage reported moderate to very high levels of satisfaction with family life. Additionally, those who felt socially supported from within and outside the family were less likely to be experiencing psychological distress or PTSD symptoms.

In summary, military families often need to deal with challenges that are not faced by civilian families, but the majority cope well and are resilient. Family processes play a central role in promoting family resilience. The following sections look at the impact of military service on more specific aspects of family life, such as couple relationships, parenting effectiveness, child maltreatment and violence in relationships, as well as social networks and support.

Couple relationships

Research on current serving members’ or ex-serving members’ relationships with spouses/partners has focused mainly on how well couples are getting along, the quality of marital relationships, and the factors that can put pressure on relationships, such as family reunion post-deployment, or mental and physical health problems.

Overall, research suggests that most military members have good relationships with their spouses/partners. For example, the Australian Timor-Leste Family Study reported that most spouses/partners felt supported and had positive perceptions of their relationship with their ADF current serving or ex-serving members (McGuire et al., 2012). There also appeared to be little conflict in these relationships. International findings are similar, with more than four-fifths of UK military members reporting satisfying and stable relationships with spouses/partners (Keeling, Wessely, Dandeker, Jones, & Fear, 2015), as did similar proportions of US serving members (Anderson et al., 2011) and Canadian spouses/partners (Dursun & Sudom, 2009).

Several factors are associated with relationship difficulties among serving members. For example, Keeling et al. (2015) found that being in an unmarried relationship; deployment issues (lack of support from spouses/partners while deployed, one’s spouse not receiving support from the military at this time, and longer deployments); family financial problems; aspects of employment (being in a higher-level position, or the work being beyond one’s experience or expertise); and family adversity while

growing up were all risks for relationship dissatisfaction among UK current serving members and reservists.

The post-deployment period can be an especially vulnerable time. Serving members are more likely to experience uncertainty about their relationship, difficulties in reintegrating, household stresses, intimate relationship problems, and communication difficulties at this time (Knobloch & Theiss, 2012). There can be conflict during this period, as indicated by one US study which found that 18% of married, returned service members reported serious conflicts with spouses, family members, and close others in their first year after a deployment (Gibbs, Clinton-Sherrod, & Johnson, 2012). (The research does not specify whether returning military members were residing at home during this period, although as all participants were married, this is likely.) Factors that increased the risk of conflict included poorer physical health, mental health problems and alcohol abuse (Gibbs et al., 2012).

Research also indicates that mental health problems such as PTSD or depression among current serving members are a risk for relationship difficulties (Allen, Rhoades, Stanley, & Markman, 2010; Goff, Crow, Reisbig, & Hamilton, 2007). Additionally, PTSD can negatively affect couple relationships after the transition to civilian life (Vogt et al., 2016). The effects on couple relationships include lower marital satisfaction, less confidence in the relationship, and poorer bonding (Allen et al., 2010); emotional withdrawal (Caselli & Motta, 1995); avoidance of communicating about certain topics (Evans, McHugh, Hopwood, & Watt, 2003); emotional ‘numbing’ (Possemato, Pratt, Barrie, & Ouimette, 2015); less self-disclosure (Solomon, Dekel, & Mikulincer, 2008); greater hostility and control (Knobloch-Fedders, Caska-Wallace, Smith, & Renshaw, 2016); increased violence (Galovski & Lyons, 2004); and higher rates of separation and divorce (Galovski & Lyons, 2004; Negrusa & Negrusa, 2014).

There appears to be little research into the effect of physical health problems among serving members on relationships with spouses/partners, and the findings are inconsistent. One study did not find greater stress in couple relationships in the early post-deployment period for serving members with combat injuries, but there were effects on parenting and serving members’ own mental health (Gorman et al., 2014). However, it has been suggested that physical injuries can increase the burden on spouses/partners, which may then impact on their relationship, suggesting there may be longer-term indirect effects (Holmes, Rauch, & Cozza, 2013). More recently, ex-serving members’ physical health problems were found to be significant predictors of relationship difficulties (Sullivan, Barr, Kintzle, Gilreath, & Castro, 2016). These effects were independent of PTSD symptoms (although PTSD symptoms were more powerful influences than physical health problems). Also, as noted above, poorer physical health increased the risk of conflict with significant others (Gibbs et al., 2012). More research

is needed to clarify the effects of physical health problems on serving members' and ex-serving members' relationships with spouses/partners.

Summing up, while research shows that most military members have good relationships with their spouses/partners in general, the period following deployment can be a time when relationships are vulnerable and may be tested. Additionally, the existence of mental health problems among current or former serving members is a risk for poorer-quality relationships, conflict, separation and divorce, and some evidence suggests that physical health problems also contribute.

Parenting

Military families can experience particular challenges in parenting their dependent children. For example, the separations that occur during deployment may alter or disrupt parent–child relationships (Sherman et al., 2015). Deployed parents of young children may miss important developmental stages (Walsh et al., 2014) or not be present at the time attachment bonds are forming (Louie & Cromer, 2014). Older children may need to 'step up to the plate' and take on additional responsibilities while their deployed parent is away (Park, 2011), as well as help at-home parents who may be struggling with caring for their families under the shadow of the risk to their serving members' lives (Paris, Devoe, Ross, & Acker, 2010). If both parents are deployed, there may be particular challenges (Bunch, Eastman, & Moore, 2007; Drummet et al., 2003), including the loss of children's usual carers and need for alternative arrangements that may involve changes in residential locality and schooling, or childcare arrangements.

There can be challenges, too, when a deployed parent returns home. This can be a time of stress and upheaval (Sayers, Farrow, Ross, & Oslin, 2009), and returning parents may have difficulty re-establishing their place in the family (Riggs & Riggs, 2011). One factor that may help reduce parenting stress at this time is having strategies in place to maintain parent–child relationships during deployment (Louie & Cromer, 2014). As Walsh and colleagues (2014) note, there may be less support from extended families and communities after deployment than during it; hence, parents may need to navigate this potentially difficult period mostly on their own.

Particular parenting challenges following deployment include difficulty reconnecting with children (Walsh et al., 2014); making co-parenting work, and developing a 'united parenting front' (Gewirtz, Pinna, Hanson, & Brockberg, 2014); scaling back tendencies to be hypervigilant and overly reactive, which can lead to family conflict (Gewirtz et al., 2014); problems when carrying out discipline, or being loath or unwilling to use it (Trautman, Alhusen, & Gross, 2015); and finding it difficult to be positive when communicating with partners and children (Trautman et al., 2015). Additionally, children aged 5 years or younger may display problematic behaviours such as avoidance, fearfulness, defiance, clinginess, or a preference for the company of the

stay-at-home parent (Barker & Berry, 2009). When children and youth were asked about post-deployment challenges for families, they mentioned getting to know their returning parents again; anxiety about future deployments or separations; concern about how their parents would get on together (Chandra et al., 2010); and distress that their returning parents seemed tired and irritable (Knobloch, Pusateri, Ebata, & McGlaughlin, 2014).

When returning parents are struggling with mental health problems such as PTSD or depression, their parenting is also often negatively affected. Serving members or ex-serving members suffering from PTSD may use less effective parenting practices (Gewirtz, Polusny, DeGarmo, Khaylis, & Erbes, 2010), and there may be less cooperation and communication in the parenting alliance (Allen et al., 2010). It has been suggested that emotional ‘numbing’ underpins the negative effects of PTSD on parent–child relationships (Ruscio, Weathers, King, & King, 2002). Children often behaved fearfully or were distant towards an ex-serving parent with PTSD (Sayers et al., 2009). Older research on Vietnam-era ex-serving members experiencing PTSD found that they encountered more problems in parenting their children, were more inclined to use aggression when parenting, and had poorer relationships with their children than ex-serving parents not suffering from PTSD (Jordan et al., 1992).

In summary, the unique challenges that military families face may put pressure on their parenting role, although as described in earlier sections, military families generally cope well and are resilient. Particular periods such as during and after deployment often require readjustment and can pose parenting difficulties. Current serving members and ex-serving members suffering mental health problems such as PTSD sometimes experience additional difficulties in parenting their children.

Maltreatment and violence

It is possible that the unique stresses that military families face, such as frequent separations because of deployment, social isolation arising from frequent geographic moves, and trauma experienced during service, make them vulnerable to child maltreatment or violence in couple relationships (Smith-Marek et al., 2016). The research that has investigated these issues is next reviewed. It should be noted that much of this research comes from the United States, which has a different service and support structure, and frequency of deployment. These findings may therefore be less relevant to the Australian situation than those in other sections of this review.

Rates of child maltreatment in military families are generally similar to those of the general population (McCarroll, Fan, Newby, & Ursano, 2008). However, child maltreatment can be more frequent during periods of deployment. For example, among US military families with substantiated records of child maltreatment, the rate of neglect was four times higher and rate of physical abuse was two times higher

during deployment, with the risk higher among civilian at-home parents than military at-home parents (Gibbs, Martin, Kupper, & Johnson, 2007). As neglect was the most frequent form of maltreatment, these findings likely reflect difficulties managing the family as a single parent, with parenting being particularly challenging (Cozza, Lerner, & Haskins, 2014). There are some indications that children of certain ages are more at risk of maltreatment during deployment. For example, one study showed that children 4 years or younger were at the greatest risk of maltreatment (Rentz et al., 2007), while another found that boys under 11 years were more likely to be physically abused and neglected, and girls over 11 years were more likely to be emotionally abused and neglected during deployment (McCarroll et al., 2008).

Another issue that has received much attention is violence in the couple relationships of military families. We look first at whether these are similar to general population rates. Similar rates of violence towards partners were found when military and civilian families were compared, after controlling for age and race (Heyman & Neidig, 1999). More recently, rates of victimisation arising from violence were found to be lower among females with military partners than those with civilian partners (Black & Merrick, 2013). Thus, there is no evidence of higher rates of violence in the couple relationships of military members than in the general community, despite the challenges that military experiences may bring.

Looking next at overall prevalence, the Australian Timor-Leste Family Study found that about 10% of serving members' partners had experienced violence post-deployment (McGuire et al., 2012). This is similar to UK prevalence rates showing 12.6% of current serving members self-reported they had been physically violent towards their partners in the weeks following deployment (McManus et al., 2012). Hence, it is likely that around one in ten military couples may experience violence in their relationship at some time.

The final issue addressed is the military factors that may be associated with violence in couple relationships, such as the post-deployment period, exposure to combat, and mental health problems. Overall, research generally shows no increase in violence towards partners from pre- to post-deployment, except for more severe types of violence or alcohol-related violence (McCarroll et al., 2010; Rabenhorst et al., 2013), suggesting that deployment by itself is not a large risk for domestic violence. However, exposure to combat during deployment does seem to be a risk for violence in couple relationships (e.g. Elbogen et al., 2010a), although it has been suggested that PTSD largely accounts for the relationship between combat exposure and violence in couple relationships (McManus et al., 2014).

Other risk factors for violence in military couples' relationships are relationship problems (Elbogen et al., 2010b); a shorter length of the relationship/marriage

(Elbogen et al., 2010b); serving members being younger (McCarroll et al., 2003); PTSD among military members, particularly symptoms of hyperarousal or difficulty managing anger (Savarese, Suvak, King, & King, 2001); trauma experienced while a prisoner of war, although this is mediated by PTSD (Elbogen et al., 2010a); and the experience of maltreatment or abuse in childhood (Elbogen et al., 2010a). Thus, a range of personal, relationship, and service-related factors are related to violence in the relationships of military members and their spouses/partners. Further, relationship dissatisfaction, low ability to cope with stress or to manage family and/or work pressures, financial difficulties, and problems with alcohol are all risks for emotional abuse in military couple relationships (Foran, Heyman, & Smith Slep, 2014).

One study has sought to identify protective factors that may mitigate the occurrence of violence in ex-serving military couples (Elbogen et al., 2014; Elbogen et al., 2012). Factors found to be protective among those with many risk factors included being in a stable living arrangement; secure employment; having the finances to cover basic needs; feeling that one had control over one's life; feeling that one had social supports; being physically healthy; and getting enough sleep.

In summary, while military families experience unique pressures, which may increase the likelihood of child maltreatment and violence, the evidence does not show elevated rates compared with the general community. Child maltreatment has been found to increase during periods of deployment, while a variety of individual, relationship and service-related factors increase the risk of violence in the couple relationships of current and former serving members. Factors protective against violence in these relationships include socioeconomic, social, psychological and physical characteristics.

1.3.8 Health

This section briefly discusses findings related to the mental and physical health and risk-taking of serving and ex-serving members, prior to discussing research findings for military family members on these aspects.

Mental health

Military service by its very nature can be a source of stress leading to mental health problems for military members and their families. Serving members can be exposed to violence and trauma, be concerned about their own safety, and feel distress, loss and grief. They can experience other psychological pressures too, such as worries about how families are coping at home. The stresses of military service are also borne by family members, including spouses/partners, children, parents and siblings, as they worry about the wellbeing of their serving relative, as well as the long-term impact of military experiences. Managing families and households as single parents during deployments can be another source of stress for military family members. Additionally,

military families can play a pivotal role in easing ex-serving members' transition to civilian life. Most research into the mental health of military members and their families examines issues such as depression, anxiety and PTSD among adults; and levels of behaviour problems among dependent children.

Mental health problems among serving and ex-serving members are well documented in Australian and international research (McFarlane, Hodson, Van Hooff, & Davies, 2011; Pinder, Iversen, Kapur, Wessely, & Fear, 2011). This issue has been extensively reviewed by Van Hooff and colleagues (2018). Another summary is therefore not provided here, except to note that research shows that mental health problems such as depression and PTSD tend to be higher among military populations than in the general community (e.g. McFarlane et al., 2011), and this risk is increased among those who have been deployed or have transitioned to civilian life (e.g. Davy et al., 2012).

We look first at mental health problems among spouses/partners, and then at the service-related factors that can affect their mental health.

Rates of emotional and psychological problems among spouses/partners were reported to be 12% in 2001 and 15% in 2004 in a US study (Booth et al., 2007). There does not appear to be similar prevalence data for Australian spouses/partners; hence, it is not possible to determine whether they are at higher risk of mental health problems than the general Australian community. The service-related factors mainly associated with a risk of mental health problems among spouses/partners are deployment both concurrently and afterwards, and mental health problems among serving and ex-serving members. International research consistently shows that deployment is a risk for higher levels of mental health problems among spouses/partners (Dursun & Sudom, 2009; Mansfield et al., 2010) which may persist into the post-deployment period, although the literature is inconsistent on this issue (Chandra et al., 2011; Dursun & Sudom, 2009; Mansfield et al., 2010). There is little Australian research on the effects of deployment on spouses/partners, although the Timor-Leste Family Study did not find it was associated with an increase in mental health problems (McGuire et al., 2012).

Mental health problems among current and ex-serving members are a clear risk for similar problems in spouses/partners, as shown by much international and Australian research (Calhoun, Beckham, & Bosworth, 2002; MacDonell, Bhullar, & Thorsteinsson, 2016; McGuire et al., 2012). There can also be long-term effects, as indicated by a follow-up of Australian Vietnam ex-serving members and their spouses/partners three decades after the Vietnam war. The risk of mental health problems was higher among spouses/partners if ex-serving members had mental health problems. Further, rates of anxiety disorders and severe recurrent depression were higher among

spouses/partners of ex-serving members than in the general Australian community (O'Toole, Outram, Catts, & Pierse, 2010).

Research into the effects of military service on children under 18 years has investigated similar issues to those of spouses/partners. Deployment has been linked to a higher prevalence of behaviour problems among dependent children in military families, and particularly youth, than their counterparts in the general population (e.g. Chandra et al., 2010; Chartrand, Frank, White, & Shope, 2008), although it should be noted that the majority of children and young people were not negatively affected. These effects were still evident when the contributions of other salient influences were included (e.g. family and serving member characteristics). Effects of deployment on children can persist into adulthood, as shown by the Australian Vietnam Veterans Family Study (VVFS) (Forrest, Edwards, & Daraganova, 2014). The VVFS found higher rates of depression, anxiety, PTSD, and suicidal thoughts, plans and actions among the adult children of Vietnam veterans by comparison with the offspring of Vietnam-era military members who had not been deployed.

Australian and international research both show that children are more likely to display behaviour problems when military parents and/or their spouses/partners experience mental health problems (Lester et al., 2010; McGuire et al., 2012). For example, the Australian Timor-Leste Family Study found that Australian children exhibited difficult behaviour significantly more often if serving members or their spouses/partners reported high psychological distress (McGuire et al., 2012), with spouses'/partners' psychological distress being particularly significant (most spouses/partners were the child's mother). Likewise, anxiety, depression and externalising behaviour problems were more common among US children when serving members and their spouses/partners were psychologically distressed (Lester et al., 2010).

In summary, research shows that deployment and mental health problems among serving and ex-serving military members are risks for spouse/partner mental health problems and behaviour problems in dependent children.

Physical health

Military service may directly impact on serving members' physical health through the injuries and disabilities arising from service. While advances in medical science and military equipment have resulted in fewer combat-related deaths, there has been a higher rate of serious injuries and impairments (Gawande, 2004). These can affect military families and lead to additional caring responsibilities if serving members need ongoing assistance in managing their injuries or disabilities (Gorman et al., 2014; Hyatt, Davis, & Barroso, 2015). Family members' mental health can be affected as well, and so can family wellbeing (e.g. Lester, 2012).

The meta-analysis conducted by Tansey, Raina and Wolfson (2013), examining physical health problems among ex-serving members over 45 years of age, found that they tended to be faring worse than civilians on general health and experienced higher rates of a range of physical health conditions. The higher rate of physical health problems among ex-serving members is likely to have flow-on effects on their families. Military service can also lead to physical stress effects. For example, increased physiological arousal among serving members was found from pre- to post-deployment and tended to persist, as reported by the Australian Middle East Area of Operations Health Study (Davy et al., 2012). Again, these physical health effects may have flow-on impacts on military families.

There is very little research on the physical health of the spouses/partners of military members. However, the Australian Timor-Leste Family Study (McGuire et al., 2012) found the proportion of spouses/partners who were in 'good', 'very good' or 'excellent' general physical health (89%) was similar to the general Australian population of women aged 25 to 44 years (91%), with no effects of deployment evident. However, more research is needed on spouses'/partners' physical health.

With regard to children's physical health, anecdotal reports indicated that sleeping problems and illnesses were more prevalent among children of deployed members than children in the civilian population (Daigle, 2013). Other research shows that access to services for injuries was higher among children during deployment (as was service use for child mental health problems and maltreatment) (Hisle-Gorman, Nylund, Tercyak, Anthony, & Gorman, 2015). Increased levels of physiological symptoms indicative of stress have also been found among children and youth of deployed service members when compared to others whose parents were not deployed or were civilians (Barnes, Davis, & Treiber, 2007). Additionally, there may be long-term physical health impacts of a family member's military service, with children of Australian Vietnam veterans more likely to experience sleep disturbances, migraines and skin conditions in adulthood than the offspring of Vietnam-era military members who had not been deployed (Forrest et al., 2014).

In summary, there seems to be little research on the physical health of spouses/partners and dependent children of military members. International research shows the physical injuries and disabilities resulting from service can significantly affect military families not just while military members are in active service. Australian research shows similar rates of general health among spouses/partners when compared to the general community, suggesting that their serving members' military service had few physical health impacts. However, parents' military service has been found to be a significant influence on children's physical health, especially if parents have been deployed. Nevertheless, the research base is small, and more research on

the physical health of military family members is needed, spanning the period from active to ex-service.

Risk-taking

Alcohol use and illicit drug use often function as maladaptive coping mechanisms in both community and military populations (Pietrzak, Pullman, Cotea, & Nasveld, 2013). They can help individuals deal with psychological problems such as depression or PTSD that can result from exposure to traumatic events during deployment (Shipherd, Stafford, & Tanner, 2005). Exposure to combat may be a particular risk, as indicated by a recent meta-analysis that showed combat, rather than deployment, was the major contributor to heavy drinking among current serving and ex-serving military members (Pietrzak et al., 2013). It has been estimated that 20% of the US general military population are heavy drinkers (Bray et al., 2010), with rates as high as 30% among those aged 18 to 25 years (Bray et al., 2007). Hooper and colleagues (2008) also report relatively high rates of heavy drinking among UK serving members. However, Australian studies suggest a different picture, although the focus has been on alcohol disorders rather than heavy drinking per se. For example, the Australian 2010 ADF Mental Health Prevalence and Wellbeing Study found that the prevalence of alcohol dependence and harmful use was significantly lower among serving members than in the Australian general population and was mostly confined to those aged 18 to 27 years (McFarlane et al., 2011).

Deployment and transition out of active service appear to be the most prominent risks for problematic drinking among current serving and ex-serving ADF members. For example, while rates of symptoms indicative of alcohol disorder were very low overall in the Middle East Area of Operations Health Study, the prevalence more than doubled from pre- to post-deployment (Davy et al., 2012). The 2015 MHWTS found considerably higher rates of problematic alcohol consumption among Australian ex-serving members than current serving members, with this especially evident among those who had returned to civilian life rather than transitioning to the reserves (Van Hooff et al., 2018). As problematic alcohol use has been found to have negative consequences for families of affected persons in the general community (Laslett et al., 2015), the higher rates among ex-serving ADF members suggests that their families may be affected too. This is an issue that can be addressed by the FWS.

Alcohol problems among spouses/partners of serving members seem to have received little attention. Only one study was located which found 2% of US spouses of current serving members reported alcohol or drug abuse in 2001, with the rate doubling to 4% in 2004 (Booth et al., 2007). Mansfield and Engel (2011) noted that there is a dearth of information about substance use among military spouses. This conclusion remains valid and more research on this topic is clearly needed. Similarly, there is a paucity of research on alcohol and other substance use among the children of military members,

although two studies found elevated rates for US adolescents whose parents were currently or recently deployed by comparison with peers whose parents were not in the military (Acion, Ramirez, Jorge, & Arndt, 2013; Reed, Bell, & Edwards, 2011). However, another did not (Chandra et al., 2011). Again, this is an area in need of further research.

Another common type of risk-taking in the general community is illicit drug use (Loxley et al., 2004). Reasons for illicit drug use are varied and range from the psychological effects of drug use for self-medication or the relief of stress associated with other life problems (Loxley et al., 2004; Sinha, 2008). While alcohol use by military members has been widely investigated in the Australian context (see above), illicit drug use seems to have received little attention. As illicit drug use is officially prohibited among current serving ADF members and leads to instant dismissal, Australian studies such as the FWS look only at illicit drug use by civilian or ex-serving family members.

Australian data from the MHWTS (Van Hooff et al., 2018) revealed that 39.4% of Ex-Serving members had used illicit drugs in their lifetime, and 16.4% in the past 12 months. Rates of illicit drug use were found to steadily increase with the lapse of time since leaving service, peaking at three years post-service, and then declining. US research shows that 2.3% of current serving members had used illicit drugs in the past month, a rate that was much lower than the civilian population rate of 12% (Bray et al., 2009). As would be expected, rates tended to be higher among younger than older current serving members. Other US research shows that rates of illicit drug use tend to be lower in current serving than civilian populations (National Institute on Drug Abuse, 2013).

Information about illicit drug use among the spouses/partners and dependent children of military members is scarce and we were unable to locate any Australian data on this issue. US data from 2015 found that among 18- to 49-year-old spouses/partners of military members, 12.8% had used illicit drugs in the past 12 months (Lipari, Forsyth, Bose, Kroutil, & Lane, 2016). This rate was similar to the rate for the general female US population of a similar age (12.9%). Among adolescents aged 12 to 17 years, 19.6% had used illicit drugs in the past 12 months compared with 17.5% of similar-aged adolescents in the civilian population (Lipari et al., 2016). Parental deployment has been found to be a risk for teenage illicit drug use, with Acion et al. (2013) showing that adolescent illicit drug use was significantly higher at this time than in the general civilian adolescent population.

A third type of risk-taking that current serving and ex-serving members may engage in is gambling. Gambling can be an additional way of coping with mental health problems, loneliness or boredom, and has the attraction of possible financial gain. Gambling problems among military members often co-occur with mental health

problems and problematic substance use (e.g. Biddle, Hawthorne, Forbes, & Coman, 2005). While there seems to be little research on problem levels of gambling in military populations, Bray and colleagues (2003) found that 3% of almost 12,800 active serving US members reported gambling behaviours that were indicative of problematic or pathological levels in 2002. Problematic gambling is known to have deleterious effects on families in the general community (Kourgiantakis, Saint-Jacques, & Tremblay, 2013); hence, more Australian information on gambling among current serving and ex-serving military members is needed. No research on gambling among the spouses/partners or children of serving members was located for this review, highlighting the need for more research in this area.

Summing up, there is considerable research on differing types of risk-taking undertaken by current serving and ex-serving members. The periods following deployment and the transition to civilian life seem to be particularly vulnerable times. However, there is very little research on risk-taking among military family members. The scant research located suggests that spouses/partners are not at elevated risk, but teenage members of military families are more likely to engage in alcohol and illicit drug use than their counterparts in the general population. As alcohol abuse, illicit drug use and gambling are assessed in the FWS, these are additional areas in which the FWS will be able to make an original, valuable contribution to what is known about military families.

1.3.9 Social support and pathways to care

Social networks and support

The existence of supportive social networks can have a large impact on military families, especially during periods of stress, for example during deployment, readjusting to life after relocation, or transitioning from military to civilian life (Padden, Connors, & Agazio, 2011; Skomorovsky, 2014). Additionally, support from others can be especially important when current serving and ex-serving members or their families are suffering with physical or mental health problems. Australian research on levels of social support among military families participating in the 2012 ADF Families Survey (Atkins et al., 2014) indicated that 52% were 'satisfied' or 'very satisfied' with their links to the general community; a similar percentage were 'satisfied' or 'very satisfied' with their capacity to access support if needed (51%); and slightly fewer were 'satisfied' or 'very satisfied' with their access to extended family support (43%; however 33% were 'dissatisfied' or 'very dissatisfied' with this last aspect).

These findings indicate that one in three of the military families surveyed felt they were not receiving sufficient extended family support, which is known to be a particularly important contributor to military family wellbeing. For example, the Australian Timor-Leste Family Study (McGuire et al., 2012) found that family support was associated

with better mental health, lower psychological distress and lower rates of PTSD among spouses/partners as well as fewer behaviour problems among children.

International research yields similar findings. Orthner and Rose (2006), for instance, reported that US military wives who perceived their families and friends to be supportive experienced fewer difficulties adjusting to military life and had higher levels of family satisfaction, while Woodworth, Canul and Morrison (2014) found that US military wives who felt socially supported scored higher on wellbeing. Social support is also associated with more effective parenting in military families (Posada, Longoria, Cocker, & Lu, 2011) and children being better able to cope with their parents' deployment (Chandra et al., 2010). On the other hand, active duty and reserve military members with severe PTSD tended to report low levels of social support (DiMauro, Renshaw, Smith, & Vogt, 2016; Sripada, Lamp, Defever, Venners, & Rauch, 2016). Additionally, their support from non-family sources waned over time, leaving those struggling with PTSD more isolated (Laffaye, Cavella, Drescher, & Rosen, 2008).

In summary, social support plays a crucial role in the wellbeing of military families, but can be difficult to maintain given the vicissitudes of deployment, relocation, and transition to civilian life. As well, social support can ameliorate the negative physical and mental health outcomes that can result from military service.

Help seeking and service use

The last broad area examined in this literature review is help seeking and service use among military families, and barriers to service use. This is an important area, given the higher rates of problems experienced by current serving and ex-serving members and family members than in the general population, which could be expected to flow on to cause a greater need for services (McGuire et al., 2015). The research reviewed below indicates that service use is not, in fact, greater among military families despite their higher rate of problems, and there are several barriers that can lead to unmet need. We first examine rates of help seeking in military families. Information on this issue comes from the *2010 Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report* (McFarlane et al., 2011), which reported that just under one-fifth of the current serving members surveyed had sought help for a stress-related, mental health, emotional or family problem in the previous 12 months, with rates being higher among females and those below the officer rank. Individuals who had been deployed or were experiencing psychological distress were more likely to have sought help, with help seeking particularly common among those who were psychologically distressed.

Additionally, a recent study compared rates of service use among Australian ex-serving members and their spouses/partners with general population rates (McGuire et al., 2015). Despite the higher rates of mental health and substance use problems evident

among ex-serving ADF members and their spouses/partners, lifetime rates of mental health service use were similar to general population rates. These findings suggest there may be a significant mismatch between service needs and provision among Australian ex-serving members and their families. Similarly, US data indicate that approximately half of ex-serving members had sought help from services, but of those seeking assistance, only half had received adequate treatment (Tanielian & Jaycox, 2008).

Turning now to children in military families, young children in US families of deployed military members had more often attended services post-deployment for mental health problems, injuries or maltreatment than counterparts in military families who did not experience a deployment. The rate was especially elevated among children whose parent had returned with a combat-related injury (Hisle-Gorman et al., 2015). Thus, service needs can be high for children in military families, especially among those whose parent has been deployed. However, as service provision and access differ across nations, the applicability of international research on this issue may be limited to a certain extent.

In summary, Australian and international research both show that considerable numbers of military families have service needs. However, many do not obtain services, suggesting there may be significant unmet need for assistance with stress-related, mental health, emotional or family-related problems. This can be due to a range of barriers, which are discussed below.

Barriers to service use

Research suggests that many military members and families do not seek the help that is needed. For example, a US population screening study of military members who had returned from deployment reported that of those showing a psychological disorder, only 23% to 40% had sought help from mental health services (Hoge et al., 2004). However, a later study revealed somewhat higher rates of mental health service utilisation (Hoge, Auchterlonie, & Milliken, 2006). A number of psychological, contextual and practical barriers may contribute to a reluctance to seek help among current and former serving members and families, as outlined by Vogt (2011).

The psychological factors identified include a perceived lack of need; concerns about stigma; and a belief that services would not be able to help (Elbogen et al., 2013; Sharp et al., 2015; Vogt, 2011). Mental health symptoms themselves can impede service use; for example, those suffering PTSD might be avoidant, while those with depression might experience apathy (Ross & DeVoe, 2014). In line with these trends, current serving and ex-serving participants in the 2015 Australian MHWTS who had probable mental health disorders were more likely to perceive barriers and stigmas to seeking help than those without probable disorders (Van Hooff et al., 2018). Finally, the

military culture may undermine service use; for example, individuals may feel they should appear strong, competent and able to deal with problems themselves; there may be privacy concerns; or a fear that service use might affect an individual's continuation in military service (Elbogen et al., 2013).

Indeed, the Australian MHWS (Van Hooff et al., 2018) found that common barriers to seeking help experienced by Current and Ex-Serving members were expense (30.0% of Ex-Serving and 6.5% of current serving), fear that their careers would be affected (30.0% of Ex-Serving and 38.7% of current serving), fear that their prospects of deployment would be harmed (18.2% of Ex-Serving and 47.4% of current serving), and difficulty getting time off work (20.6% of Ex-Serving and 19.9% of current serving). The most common stigmas endorsed were that others would lose confidence in them (40.0% of Ex-Serving and 44.6% of current serving), people might treat them differently (32.5% of Ex-Serving and 36.3% of current serving), the serving member would be seen as weak (28.8% of Ex-Serving and 31.3% of current serving), and they would feel worse about themselves if they were unable to solve their own problems (35.5% of Ex-Serving and 27.2% of current serving).

Practical barriers, some of which apply particularly to spouses/partners and children, include not being able, or not knowing where, to obtain services; transportation issues; difficulty arranging appointments or getting time off work; geographic isolation; and inadequate healthcare insurance (Ross & DeVoe, 2014). Serving participants in the *Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report* (McFarlane et al., 2011) cited some of these barriers, with 15% saying they had found it difficult to get time off work and 6% not knowing where to get help. Similarly, the Australian Timor-Leste Family Study (McGuire et al., 2012) found that approximately one-third of spouses/partners of current serving and ex-serving members felt that barriers would stop them from seeking help for mental health problems, with the largest barrier being the cost of services. Additionally, over half of spouses/partners suffering with PTSD worried that if they sought help, others would treat them differently, or that they would be seen as weak, as well as perceiving treatment to be too expensive.

In summary, there can be many psychological, contextual and practical barriers that prevent current and former serving members and their families from accessing needed services. While there is considerable research on barriers to service use among military members, the barriers and service needs of their families has received little attention. This is another area in which the FWS could make a valuable contribution.

1.4 Aims, objectives and scope of Part 1

This literature review has shown that while military families may often not be at the forefront of public discourse, they play an integral role in supporting serving and ex-serving members, as well as the Australian Defence Force overall. It has also demonstrated that the families themselves are affected by their family members' military service over many areas of life. Where possible, Australian research has been highlighted, but the review makes clear that this is lacking in a number of areas. More Australian research is needed to shed light on how our own military families are faring and to confirm that the findings reported in other countries and cultures apply in the Australian context.

Additionally, it is clear that the research that has been undertaken on military families has focused almost exclusively on spouses/partners and dependent children under 18 years of age. Thus, research is only just beginning to look at effects on other types of family members, such as serving members' parents, siblings or adult offspring, with the contributions these family members make to the wellbeing of serving members and their immediate families largely unknown.

In short, substantial gaps remain in what is known about military families. The FWS aims to make a valuable contribution both in providing new information on the welfare of Australian military families and in addressing some of the knowledge gaps in the literature.

1.4.1 Aims and objectives

Specifically, the primary aims of Part 1 of the FWS are:

- to provide an overview of health and wellbeing status (i.e. mental health, physical health, couple relationships, risk-taking behaviours) of all the military families participating in the FWS
- to compare levels of health and wellbeing among families whose ADF members are current serving or ex-serving
- to explore the help-seeking behaviour of families of ex-serving members after the transition to civilian life and how it compares to the help-seeking behaviour of families of the 2015 Regular ADF members.

The key objective of the study is to close the gap in Australian research evidence concerning the needs of military families during and following ADF service, thereby providing:

- valuable new insights for the Department of Defence (Defence) and the Department of Veterans' Affairs (DVA) evidence-based policy development and service provision
- a framework for further detailed analyses and identification of key priority areas for further Defence and DVA research attention.

Part 1, therefore, provides a comprehensive overview of the health and wellbeing of family members of current serving and ex-serving ADF members, as well as a comparison between these two groups.

1.4.2 Scope

Part 1 focuses on current serving and ex-serving ADF members and their families, specifically:

- **Current Serving ADF members** – those who were on active duty in the ADF at the time of data collection, i.e. they were Regular ADF members in 2015
- **Ex-Serving ADF members** – those who transitioned from ADF active service between January 2010 and December 2014, not including the peri-transition period. The Ex-Serving group includes ADF members who were completely discharged either voluntarily or involuntarily (for medical or administrative reasons), transferred to the Active Reserves, or transferred to the Inactive Reserves
- **family members** of Current Serving and Ex-Serving members, with most being their spouses/partners but also including their adult children and parents.

Part 1 uses data from the following three sources (see Chapter 2 for more details):

- the **Military and Veteran Research Study Roll** – an administrative database of ADF members (Current Serving and Ex-Serving)
- the **Mental Health and Wellbeing Transition Study dataset** – self-report questionnaires completed by Current Serving and Ex-Serving ADF members (via online or hard copy surveys)
- the **Family Wellbeing Study dataset (quantitative)** – self-report questionnaires completed by family members of Current Serving and Ex-Serving ADF members (online surveys).

1.4.3 Questions addressed

Part 1 addresses the following six questions:

1. What are the circumstances of families of current serving and ex-serving ADF members on:
 - a. demographic characteristics
 - b. living arrangements and residential mobility
 - c. employment and financial hardship?
2. What are family members' perceptions of the effect of current or prior military service on:
 - a. various aspects of ADF members' lives (health, wellbeing, social networks, family wellbeing)
 - b. various aspects of family members' lives (health, wellbeing, social networks, family wellbeing)?
3. What is the quality of within-family relationships in coupled military families; are there differences according to the current serving or ex-serving status of their ADF members on:
 - a. marital relationship quality
 - b. relationships with children and parenting practices
 - c. children's adjustment?
4. How healthy are family members of current serving and ex-serving ADF members; are there differences according to the current serving or ex-serving status of their ADF members on:
 - a. mental health
 - b. physical health
 - c. risk-taking behaviours?
5. What are the care pathways and service supports:
 - a. used by the families of current serving and ex-serving ADF members
 - b. suggested to current serving and ex-serving ADF members by their family members?

6. When multiple factors are included together, what factors affect the health and wellbeing and family relationships of families, including:
 - a. military service characteristics
 - b. current and ex-serving ADF members' health and wellbeing
 - c. family members' health and wellbeing
 - d. family characteristics and relationships?

2 Methodology

This chapter provides a description of the Family Wellbeing Study (FWS) design, including the methods used to recruit the FWS sample; characteristics and representativeness of the sample obtained; subgroups used for statistical analyses; and the data collection methods and measures used.

2.1 Study design – recruitment of sample

A two-stage process was used to recruit the sample for the FWS.

In **Stage 1**, ADF members who were discharged from full-time active ADF service between 2010 and 2014 either voluntarily or involuntarily (comprising those who had transitioned to civilian life; become active or inactive reservists; or were Ab-initio reservists – termed ‘Ex-Serving’ from now on), and ADF members who were on full-time, active duty in 2015 (termed ‘Current Serving’ from now on) were recruited to participate in the Transition and Wellbeing Research Programme’s Mental Health and Wellbeing Transition Study (MHWTS population; termed ‘Programme population’ hereafter) led by the Centre for Traumatic Stress Studies.

All individuals recruited to the Mental Health and Wellbeing Transition Study (termed ‘MHWTS respondents’) were assessed on mental health problems, psychological distress, physical health problems, social and financial wellbeing, pathways to care, and occupational exposure via a 60-minute self-report questionnaire, which was completed either online or by hard copy. Each participant received a slightly different questionnaire tailored to their current ADF status (Ex-Serving or Current Serving) that sought information on demographics; military service and deployment history; transition processes and experiences; and employment. Additionally, core, validated measures of psychological and physical health were used across all MHWTS respondents regardless of their ADF status, and replicated where possible measures used in previous surveys.

All MHWTS respondents (Current Serving and Ex-Serving ADF members) were asked as part of their survey to nominate significant family members (e.g. their spouses/partners, parents, adult children, siblings) who could be invited to participate in the FWS, noting that this study was being led by the Australian Institute of Family Studies. More specifically, MHWTS respondents were asked:

- to provide contact details for nominated family members as possible FWS participants
- to inform the nominated family members that their contact details had been provided to the Australian Institute of Family Studies, which would subsequently be contacting these family members to invite them to take part in the FWS
- to agree to have their own MHWTS survey data linked to the FWS survey data collected for their nominated family members.

In **Stage 2**, all nominated family members of MHWTS respondents (i.e. those individuals who had previously been informed about the FWS and had their contact details supplied) were invited to participate in the FWS and complete a 30-minute online survey (those who completed the FWS survey are termed ‘FWS respondents’ or ‘FWS participants’ from now on). The FWS survey was personalised and tailored to differing respondent types using specific-purpose questions, responses categories, data insertions, and skip logic. For example, some questions included the name or sex of the MHWTS respondent in the question, while others included information previously supplied by the MHWTS respondent about their dependent child, such as the child’s name, sex and age. This increased the accuracy of the questions and created a highly personalised experience for each FWS participant.

As in the MHWTS, each FWS participant received a slightly different questionnaire that took into account their demographic characteristics, MHWTS respondent’s military service and deployment history; how FWS participants were related to their MHWTS respondents (i.e. spouse/partner, adult child, parent, etc.); and the military experiences of the family members themselves. The core measures of psychological and physical health, pathways to care, and economic wellbeing remained the same across all types of FWS participants, and where possible replicated the measures used in the MHWTS and previous flagship surveys to increase comparability. More details on data collection, including the pilot study conducted, cognitive testing, and reminder strategies can be found in Appendix A.

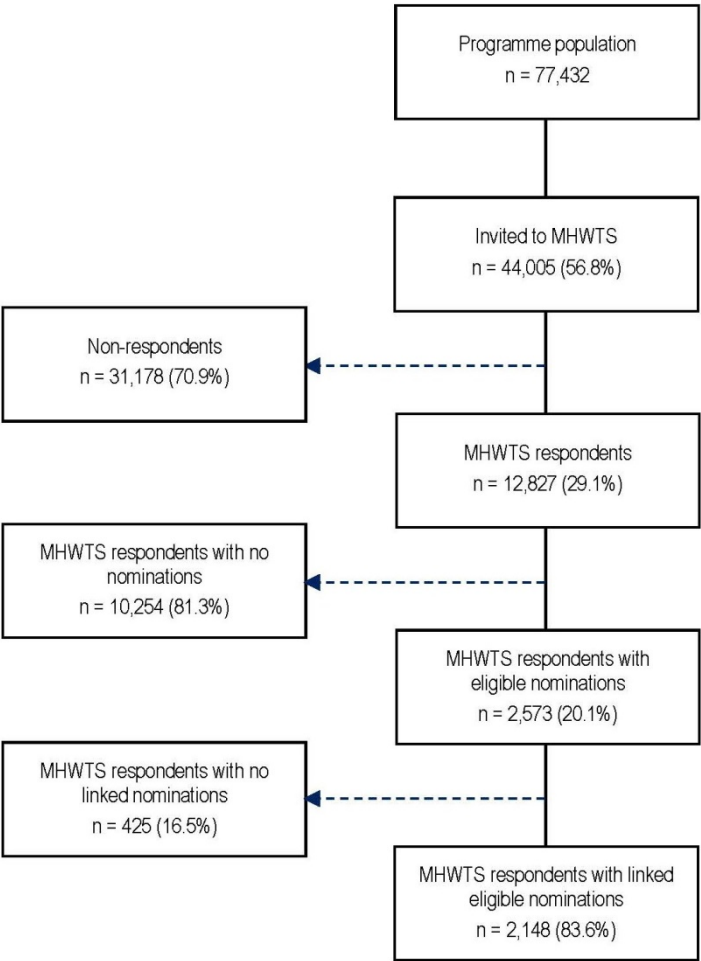
2.2 Families in focus

Figure 2.1 shows the steps taken to identify the potential FWS sample. It shows:

- the total ADF cohort as at 2015 (‘Programme population’)
- the number of ADF members (Current Serving and Ex-Serving) who were invited to participate in the MHWTS

- the proportion of those invited to take part in the MHWTS who responded ('MHWTS respondents')
- the number of MHWTS respondents who provided eligible nominations for family members ('MHWTS respondents with eligible nominations')
- the proportion of MHWTS respondents who agreed for their data to be linked to their eligible family member's data ('MHWTS respondents with linked eligible nominations').

Figure 2.1 Recruitment steps for the Family Wellbeing Study



Note: These numbers differ from the MHWTS by $n = 22$ because some MHWTS respondents withdrew after participating in the MHWTS, or had died. However, their family members had taken part in the FWS. A decision was taken to exclude these family members' data from the FWS dataset.

Out of whole ADF population (n = 77,432), 56.8% (n = 44,005) were invited to participate in the MHWTS.³ Overall, a response rate of 29.1% was achieved for the MHWTS across both Current Serving and Ex-Serving ADF members (calculated by the number of total respondents (n = 12,827) divided by the number of the total invited (n = 44,005)). Looking specifically at the Current Serving and Ex-Serving participating subgroups, the response rate for the Current Serving group was higher than that of the Ex-Serving subgroup (42.3% and 18.0% respectively).

Around 20% of MHWTS respondents provided eligible nominations for family members (i.e. provided family contact details and agreed to inform family members about the FWS, n = 2,573) (calculated by the number of MHWTS respondents with eligible nominations (n = 2,573) divided by the number of MHWTS respondents (n = 12,827). MHWTS respondents who provided nominations were also asked whether they agreed to link their survey data to their family member's FWS survey data, with more than four in five (83.6%) agreeing to do so.

Across the MHWTS respondents who provided nominations, 61.3% (n = 1,577) were Current Serving, 10.2% (n = 262) were Ex-Serving Active Reserves, 9.8% (n = 253) were Ex-Serving Inactive Reserves, 12.1% (n = 312) were discharged, and 6.6% (n = 169) were Ab-initio⁴ in 2015 (Table 2.1). Due to the small number of nominated active reservists, Inactive Reserves, and discharged MHWTS respondents, these three groups were combined and are subsequently referred to as 'Ex-Serving'.

Given that the experiences of Ab-initio members are very different from current or Ex-Serving members, and the number of this type of respondent is small, this group was excluded from the analyses conducted for the FWS.

Table 2.1 Military status of MHWTS respondents with eligible nominations

Military status	Collected sample		Analysis sample	
	n	%	n	%
Current serving	1,577	61.3	1,577	65.6
Ex-serving			827	34.4
Active reservists	262	10.2		
Inactive reservists	253	9.8		
Discharged	312	12.1		
Ab-initio	169	6.6		
Total	2,573	100.0	2,404	100.0

³ For details on the MHWTS recruitment and participation rate, see Van Hooff et. al. (2018).

⁴ Ab-initio reservists differ from other reservists in that they enlisted as Reserves from the beginning and have never served in the Permanent/Regular ADF force (except for short periods of continuous full-time service). Their military experiences are therefore likely to be quite different to the Current Serving or Ex-Serving groups of ADF members studied in the MHWTS and FWS. Their family members' data were therefore not included in analyses.

Therefore, Part 1 focuses on the following two family populations:

- **Population 1** – family members of MHWTS respondents who were current serving in 2015 (on full-time, active duty)
- **Population 2** – family members of Ex-Serving MHWTS respondents who had been discharged from full-time ADF service between 2010 and 2014, either voluntarily or involuntarily. This group included families whose ADF members had transitioned to civilian life, or were Active or Inactive reservists.⁵

2.3 Nomination and response rates for the FWS

Figure 2.2 and Figure 2.3 summarise the process used to recruit family members of Current Serving and Ex-Serving MHWTS respondents into the FWS; the proportions who participated; and the proportions with linked MHWTS respondents' data.

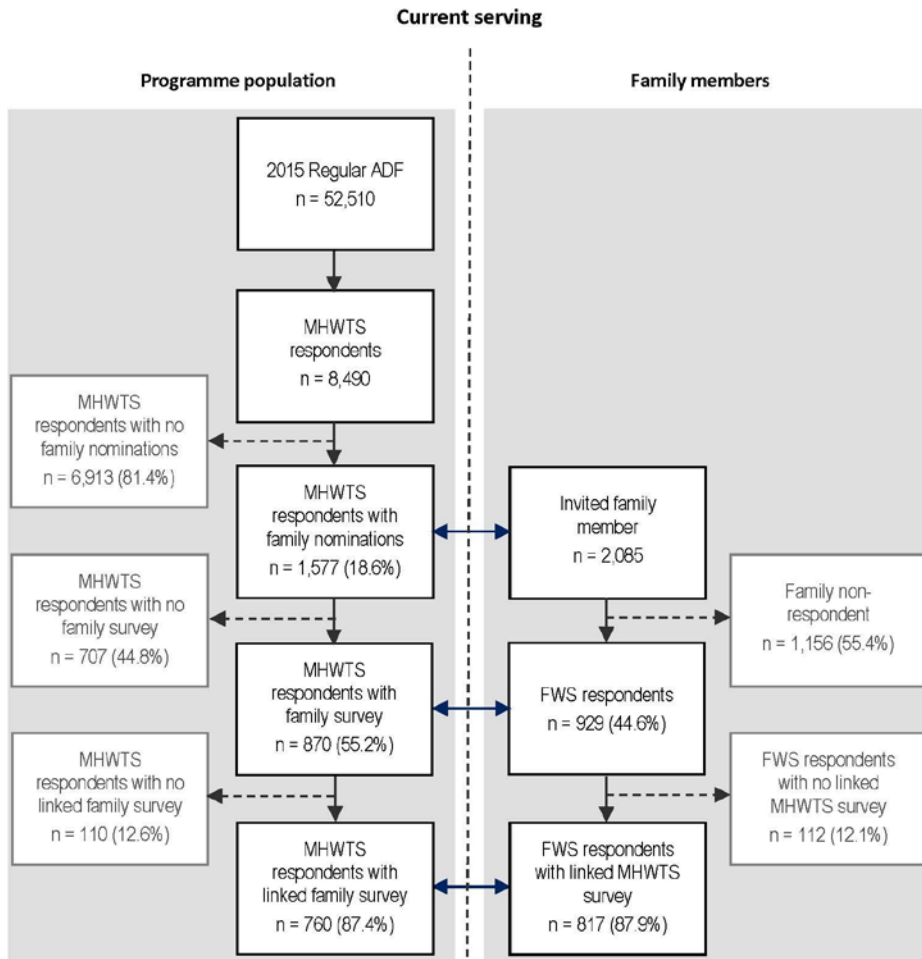
MHWTS respondents were able to nominate more than one family member; hence, the numbers on the right side of the figures are slightly larger than those on the left side as they reflect the presence of multiple family members. It should be noted that the figures include only those family members (invited family members) who were included in the analysis sample (family respondents). A small number of family members participated in the FWS but did not provide enough demographic information or did not complete key outcome measures and were therefore excluded (n = 156). For details on exclusions, please refer to Appendix B.

Among Current Serving MHWTS respondents (Figure 2.2), 18.6% (n = 1,577) provided contact details for 2,085 family members. Family data was collected for 55.2% of these MHWTS respondents (n = 870). For most but not all (87.4%), permission was given for FWS data to be linked to their MHWTS data.

In all, just over 2,000 family members of the Current Serving Programme population were invited to participate in the FWS (n = 2,085). Around 45% of those invited subsequently participated (n = 929; 44.6%; this number includes multiple family members nominated by MHWTS respondents). For 87.9% of FWS participants, their data were linked to Current Serving MHWTS respondents' data (n = 817).

⁵ While reservists are technically still serving, they have been classified as Ex-Serving here as they are no longer in full-time service and their access to services such as health/social services or housing assistance differs as a result of their transition status.

Figure 2.2 Nomination rate and FWS response rate for families of Current Serving MHWTS respondents

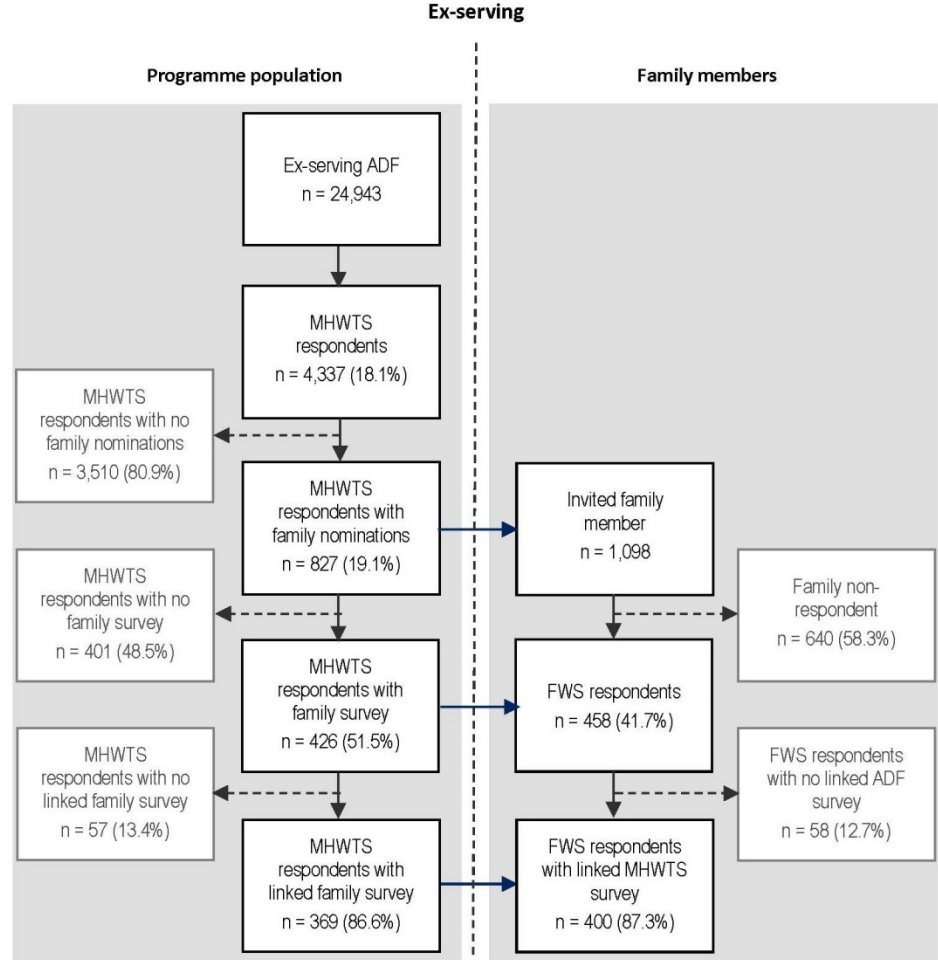


Note: These numbers differ from the MHWTS by n = 10 because some MHWTS respondents withdrew after participating in the MHWTS, or had died. However, their family members had taken part in the FWS. A decision was taken to exclude these family members' data from the FWS dataset.

Next, Figure 2.3 shows similar details for Ex-Serving MHWTS respondents. A total of 19.1% provided contact details for n = 827. Family data were collected for 51.5% (n = 426) and for 86.6% of these MHWTS respondents, family data were linked to their MHWTS data.

Close to 1,100 family members of Ex-Serving MHWTS respondents were invited to take part in the FWS (n = 1,098). Around 42% (n = 458; 41.7%) participated in the study and for 87.3% of those who participated, their data were linked to Ex-Serving MHWTS respondents' data (n = 400).

Figure 2.3 **Nomination rate and FWS response for families of Ex-Serving MHWTS respondents**



Note: These numbers differ from the MHWTS by $n = 12$ because some MHWTS respondents withdrew after participating in the MHWTS, or had died. However, their family members had taken part in the FWS. A decision was taken to exclude these family members' data from the FWS dataset.

2.4 Representativeness of MHWTS respondents with family data

Given that slightly less than half of the family members invited to take part in the FWS participated, it is important to investigate the representativeness of the obtained sample. Unfortunately, it is not possible to compare the characteristics of the family members who participated in the FWS to the population of all ADF military families because relevant data are not available. However, it is possible to examine how representative the MHWTS respondents whose family members participated in the

FWS were compared to the total Programme population on a number of demographic characteristics extracted from the Military and Veteran Research Study Roll (MVRSR).

The MVRSR is a database containing details of current serving and ex-serving ADF members (reservists and those who transitioned out of the ADF between 2010 and 2014) in 2015. It does not comprise the total ADF population but consists of a sample of the current serving ADF population and a census of those who had left full-time service between 2010 and 2014. For the purposes of Part 1, the following de-identified details were obtained: age, sex, rank, service type, and medical fitness for service.⁶ These variables were used to shed light on the representativeness of the sample of MHWTS respondents whose family members participated in the FWS by comparison with the entire Programme population contained in the MVRSR database.

Figure 2.4 to Figure 2.8 present differences between the following samples:

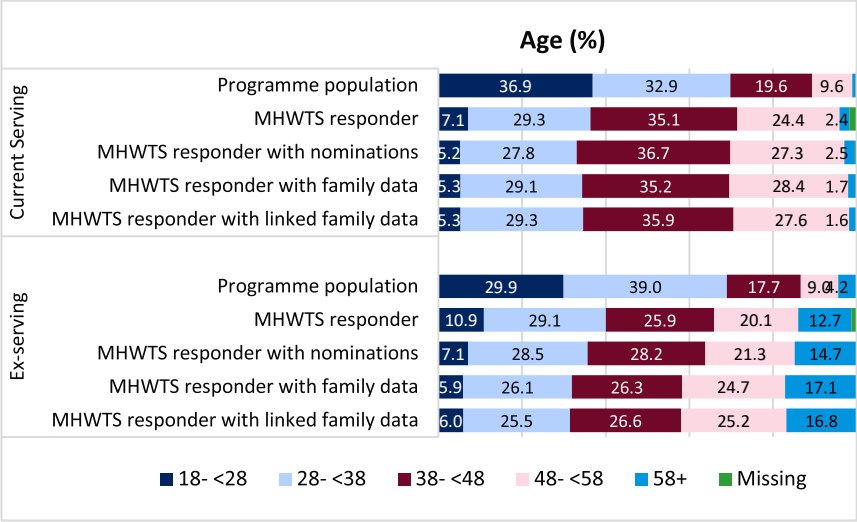
- Sample 1: The Programme population
- Sample 2: MHWTS respondents
- Sample 3: MHWTS respondents with family nominations
- Sample 4: MHWTS respondents with family data
- Sample 5: MHWTS respondents with linked family and MHWTS data.

Overall, compared to the Programme population, MHWTS respondents with family data tended to be older (Figure 2.4). Thus, 36.9% of the Current Serving Programme population were aged 18 to < 28 years, while in the corresponding MHWTS sample only 7.1% were in this age bracket, as was 5.3% of the MHWTS sample with family data. Similarly, in the Ex-Serving Programme population, 29.9% were in this age bracket compared to 10.9% of all Ex-Serving MHWTS respondents and 5.9% of Ex-Serving MHWTS respondents with family data.

Next, comparing all MHWTS respondents with the subgroup who had family data, those with family data also tended to be slightly older (e.g. 28.4% of Current Serving MHWTS respondents with family data were 58 or more years of age compared with 24.4% of all Current Serving MHWTS respondents; while 24.7% of Ex-Serving MHWTS respondents with family data were 58 or more years compared with 20.1% of all Ex-Serving MHWTS respondents). However, these differences were not statistically significant.

⁶ Medical Employment Classification is an administrative process designed to monitor physical fitness and medical standards in the ADF and is divided into four levels. For the purposes of Part 1, it was recoded into two levels: 'fit' – those classified as fully employable and deployable (could have some restrictions), and 'unfit' – those not fit for deployment, their original occupation and/or further service.

Figure 2.4 Representativeness of MHWTS responding sample with family data, by age of MHWTS respondents



No differences in age distributions were observed between those who provided nominations, agreed to link family data, or whose family members participated in the FWS.

The next aspect examined is whether there were differences in the sex distributions of Current Serving and Ex-Serving samples (Figure 2.5). Females were significantly over-represented in the Current Serving MHWTS responding sample by comparison with its corresponding Programme population (21.1% and 9.3% respectively). When the Ex-Serving Programme population and Ex-Serving MHWTS responding sample were compared, there were no significant differences in their proportions of males and females (e.g. 86.9% and 84.3% were male, respectively).

Significant differences were also found when the Current Serving MHWTS respondent subgroup with family data was compared to the Current Serving Programme population (15.4% and 9.3% were female, respectively), but not when it was compared to the total Current Serving MHWTS respondent group.

There were no significant differences when Ex-Serving groups were compared (all MHWTS respondents and the group with family data). Similarly, non-significant findings were also found when the MHWTS subgroups who agreed to link their survey data, or whose family members participated in the FWS, were compared to the total MHWTS respondent subgroups (Current Serving and Ex-Serving).

Figure 2.5 Representativeness of MHWTS responding sample with family data, by sex of MHWTS respondents

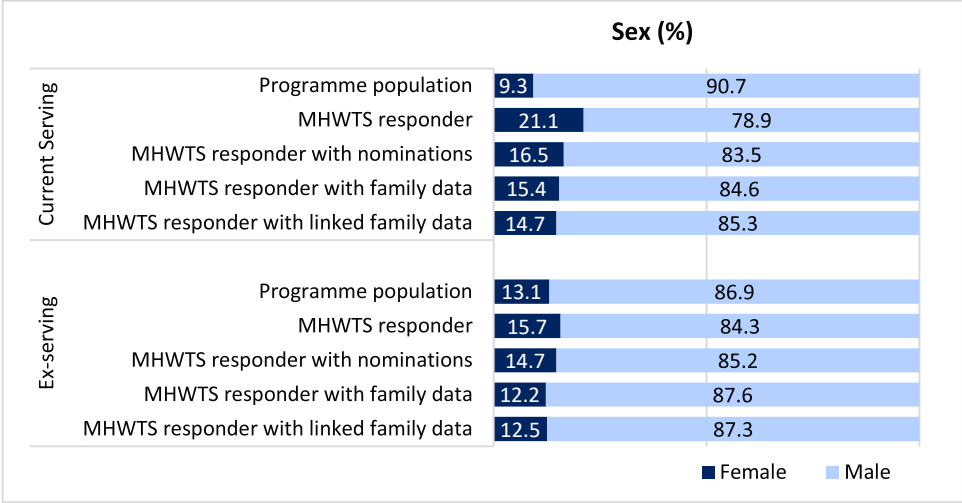
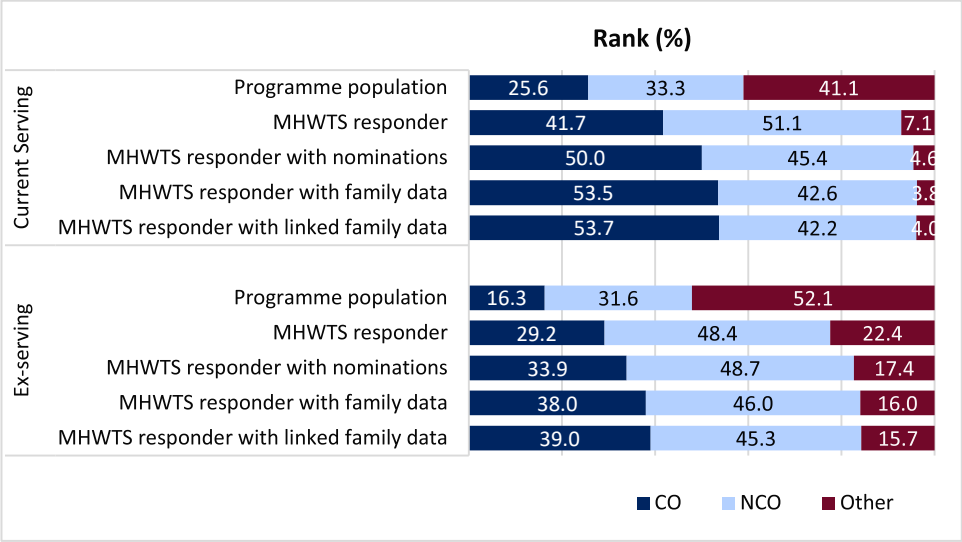


Figure 2.6 displays the findings when differences by military rank were investigated (comparing the proportions of Commissioned Officers, Non-commissioned Officers, and Other Ranks in the various populations and samples). Commissioned Officers were over-represented in both the Current Serving and Ex-Serving total MHWTS responding groups and subgroups with FWS data by comparison with their corresponding Programme populations, with around twice the percentages in the MHWTS groups. Additionally, those in Other Ranks were under-represented in the MHWTS responding groups (e.g. 7.1% of the total Current Serving MHWTS respondent group had an ‘other rank’ compared with 41.1% of its parallel Programme population, and 22.4% compared with 52.1% for analogous Ex-Serving groups).

Current or Ex-Serving Commissioned Officers were also over-represented when the MHWTS responding groups with family data were compared to their corresponding, total MHWTS responding groups (e.g. 53.5% of the Current Serving group with family data were Commissioned Officers compared with 41.7% of the total Current Serving MHWTS responding group, while rates were 38.0% and 29.2% when parallel Ex-Serving groups were compared).

There were also significant differences when the total MHWTS responding groups were compared to the MHWTS responding groups with linked FWS and MHWTS respondent data (Current Serving and Ex-Serving).

Figure 2.6 Representativeness of MHWTS responding sample with family data, by rank of MHWTS respondents



Note: CO = Commissioned Officers; NCO = Non-commissioned Officers; Other = Other Ranks.

Regarding service type, Figure 2.7 shows that the Air Force was over-represented by about 9% in the Current Serving total MHWTS responding sample and MHWTS responding sample with family data by comparison with its corresponding Programme population. The Army was under-represented by around the same amount. The percentages in the Navy were comparable across the Current Serving Programme population and various MHWTS samples. The same types of differences were found when Ex-Serving samples were compared. For instance, 29.6% of Ex-Serving MHWTS respondents with family data were in the Air Force compared with 16.9% of the Ex-Serving Programme population. Around 5% fewer Ex-Serving MHWTS respondents with family data were in the Army and Navy compared to the Ex-Serving Programme population.

No significant differences by service type were observed between MHWTS respondents who provided nominations, agreed to link family data, or whose family members participated in the FWS.

Figure 2.8 demonstrates that the Current Serving and Ex-Serving populations and samples did not significantly differ on the proportions who were classified as physically fit to serve.

Figure 2.7 Representativeness of MHWTS responding sample with family data, by type of service of MHWTS respondents

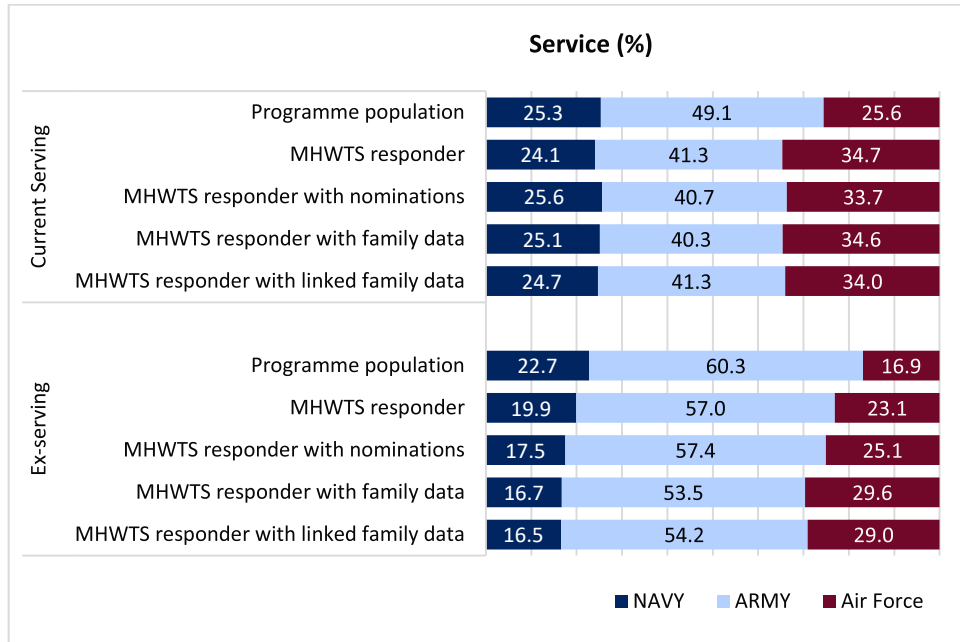
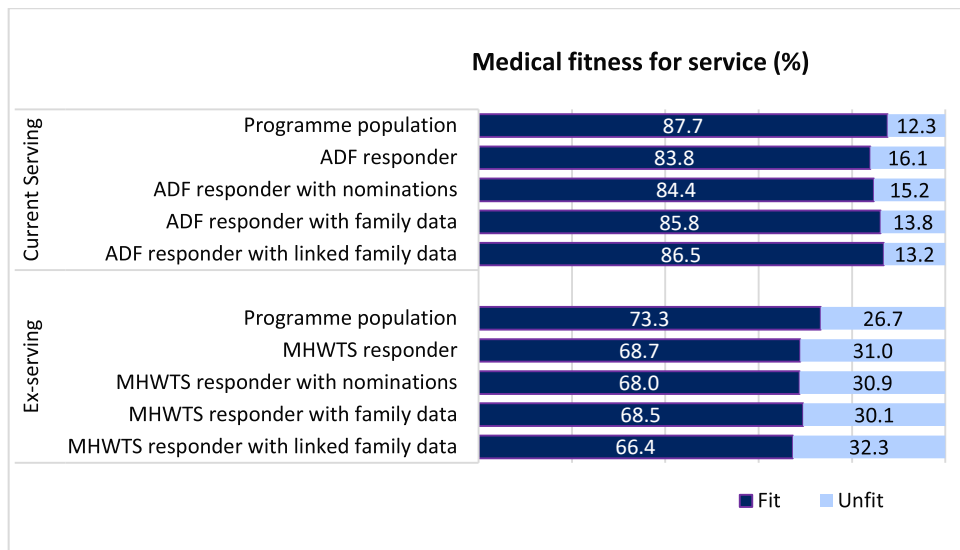


Figure 2.8 Representativeness of MHWTS responding sample with family data, by the medical fitness for service of MHWTS respondents



In summary, when the entire MHWTS responding groups were compared to their corresponding Programme populations, MHWTS respondents were found to be significantly older (both Current Serving and Ex-Serving); have a significantly higher proportion of females (Current Serving only); contain a significantly higher percentage of individuals with higher ranks (Current Serving and Ex-Serving) and fewer in other types of ranks below the officer level (Current Serving and Ex-Serving); and comprise a higher proportion of Air Force members, fewer Army members and similar percentages of Navy members (Current Serving and Ex-Serving). However, there were no significant differences on the proportions who were medically fit for service.

There were fewer significant differences when the total MHWTS respondent groups (Current Serving and Ex-Serving) were compared to corresponding MHWTS respondent groups with family data. Thus, there were no significant differences on MHWTS respondents' age, service type, or the proportion who were medically fit for service. The proportion of female MHWTS respondents was significantly higher in the Current Serving group with family data than the total Current Serving MHWTS respondent group, but not in similar Ex-Serving groups. Both Current Serving and Ex-Serving MHWTS responding groups with family data contained a greater percentage of individuals with higher ranks than their corresponding total MHWTS responding groups.

With only one exception (MHWTS respondents' rank), no significant differences were found when the MHWTS responding groups with family data were compared with subgroups who had linked MHWTS and FWS data (Current Serving and Ex-Serving).

The over-representation of older, female, higher ranking, and Air Force MHWTS respondents in the total MHWTS responding sample may have introduced some level of bias if the age, sex, rank and service type of MHWTS respondents could be expected to exert effects on the findings. The bias observed may limit generalisation to the broad total current serving or ex-serving populations. Similarly, while the FWS sample is comparable to the total MHWTS responding sample on several characteristics, it over-represents females (Current Serving only) and higher ranks (Current Serving and Ex-Serving). Thus, caution is needed when generalising the findings in Part 1 beyond the sample recruited and studied.

2.5 Number of nominations by MHWTS respondents

MHWTS respondents were asked to provide contact details for up to three family members. Table 2.2 reports the number of nominations provided, the number of family members who participated per MHWTS respondent, and the number who had linked FWS and MHWTS data. The findings were very similar across Current Serving and Ex-Serving MHWTS respondents. Thus, around 75% provided contact details for only one family member; 17.3% of Current Serving MHWTS respondents and 19.0% of Ex-Serving MHWTS respondents provided details for two family members; and around 7% for three family members. It was extremely common for only one family member to participate (93–94% of Current Serving and Ex-Serving), while around 6% had two participating family members and fewer than 1% had three participating family members.

Table 2.2 **Number of nominations provided, by MHWTS respondent type**

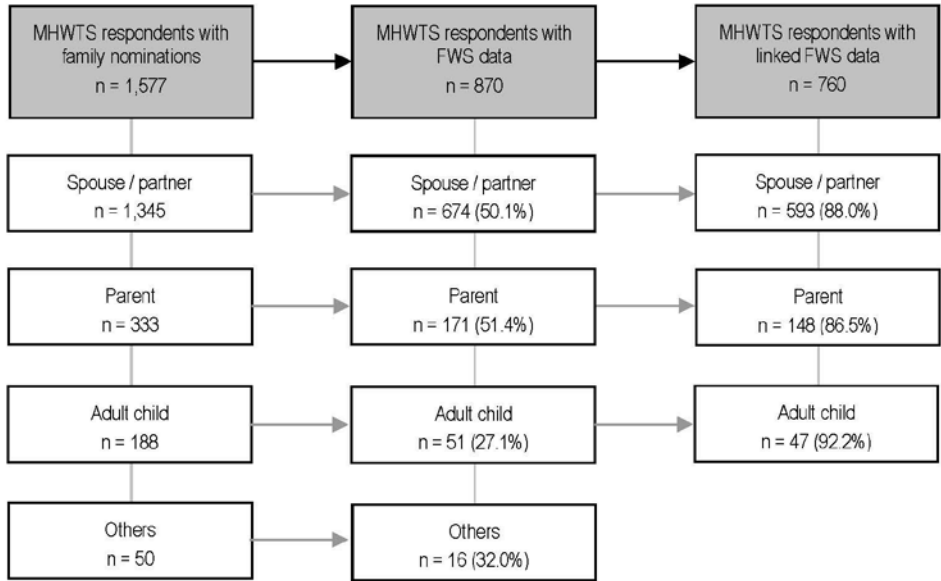
	MHWTS respondents with nominations		MHWTS respondents with family data		MHWTS respondents with linked family and MHWTS data	
Current Serving MHWTS respondents						
1 nomination, n (%)	1,185	(75.1)	816	(93.8)	708	(93.2)
2 nominations, n (%)	273	(17.3)	50	(5.7)	48	(6.3)
3 nominations, n (%)	119	(7.5)	4	(0.5)	4	(0.5)
Total, n (%)	1,577	(100.0)	870	(100.0)	760	(100.0)
Ex-Serving MHWTS respondents						
1 nomination, n (%)	1,185	(75.1)	816	(93.8)	708	(93.2)
2 nominations, n (%)	273	(17.3)	50	(5.7)	48	(6.3)
3 nominations, n (%)	119	(7.5)	4	(0.5)	4	(0.5)
Total, n (%)	1,577	(100.0)	870	(100.0)	760	(100.0)

2.6 Relationship of FWS participants to their MHWTS respondents

MHWTS respondents were asked to nominate a spouse/partner (or ex-spouse/partner), parent or parent figure, child aged 18 and over, or other family member who could be invited to take part in the FWS. Figure 2.9 and Figure 2.10 provide a breakdown of how family members were related to their Current Serving and Ex-Serving nominating MHWTS respondents.

Current Serving MHWTS respondents provided contact details for 1,345 spouses/partners (ex-spouses or current), 333 parents, 188 adult children, and 50 other family members, e.g. siblings (Figure 2.9). Out of all spouses/partners (ex or current), 50.1% participated in the FWS (n = 674) and for 88% of those who participated, their FWS data were linked to MHWTS respondents' data (n = 593). A total of 51.4% of parents also participated in the FWS and FWS and MHWTS respondent data were linked for 86.5% of these participants. A much smaller proportion of the adult children nominated by Current Serving MHWTS respondents agreed to participate in the FWS. Out of the 188 adult children nominated, only 51 took part (27.1%), although for 92.2% of the adult children who took part, their FWS and MHWTS data were linked.

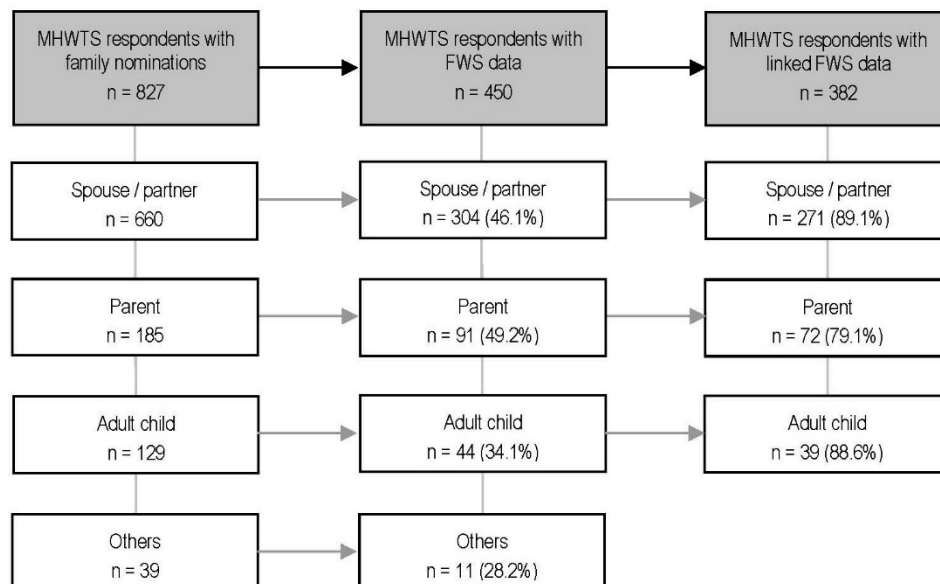
Figure 2.9 FWS participating family members, by relationship to Current Serving MHWTS respondents



Ex-Serving MHWTS respondents provided contact details for 660 spouses/partners (ex-spouses or current), 185 parents, 129 adult children, and 39 other types of family members (Figure 2.10). Out of all spouses/partners (ex-spouses or current), 46.1% participated in the FWS (n = 304), with FWS data being linked to MHWTS data for 89.1% of participating spouses/partners (n = 271). A similar proportion of parents also participated in the FWS (49.2%), but FWS data were linked to MHWTS respondents' data for only 79.1% of participating parents. As found for the Current Serving subgroup, a smaller proportion of nominated adult children agreed to participate in the FWS. Out of 129 adult children nominated, only 44 took part (34.1%), with FWS and MHWTS data being linked for 88.6% of participating adult children.

As the number of respondents in the 'other family member' group was small (n = 16 of Current Serving and n = 11 of Ex-Serving), these cases are included in the findings reported in Section 3.1, 'Meet the families', but are not included in subsequent analyses and sections.

Figure 2.10 FWS participating family members, by relationship to Ex-Serving MHWTs respondents



2.7 Differing samples used in statistical analyses

The following issues were taken into account when deriving the various samples used in the statistical analyses undertaken to examine the key research questions of the FWS:

- differences in the numbers of Current Serving and Ex-Serving MHWTs respondents (as comparison of families of Current Serving and Ex-Serving MHWTs respondents was a major focus of the study)
- differences in the number who took part across FWS respondent types (spouses/partners, parents, adult children)
- incomplete availability of linked MHWTs data
- the potential sample sizes.

The differing samples used in the statistical analyses of the FWS dataset are presented in Table 2.3. It should be noted that due to small sample sizes, MHWTs respondent linked data for parents and adult children were not utilised, although the FWS data they provided are. For the analyses presented in Section 3.1 of Part 1 ('Meet the families'), Sample 1 is used. For the analyses presented in sections 3.2 (spouses/partners), 3.3 (adult children) and 3.4 (parents), samples 3, 5 and 6 are used, respectively. For the analyses presented in Chapter 4, where data for MHWTs and FWS respondents are both used, samples 2 and 4 are used.

Table 2.3 FWS samples derived for FWS data analysis

Sample	Type of respondent	Family member of MHWTS respondent (n)	
		Current Serving	Ex-Serving
Sample 1	All FWS respondent data	929	458
Sample 2	Linked FWS respondent data	817	400
Sample 3	Partner/spouse data	677	306
Sample 4	Linked partner/spouse data	596	272
Sample 5	Adult children data	54	48
Sample 6	Parents data	182	93

2.8 Differences between MHWTS respondents with and without FWS data, by family relationship

To gain further insight into whether recruitment to the FWS has introduced bias, MHWTS respondents with and without FWS data were compared on key demographic and mental health characteristics. We look first at differences between MHWTS respondents with and without FWS data from any type of family member, then differences between MHWTS respondents with and without spouse/partner data, parent data, or adult child data.

2.8.1 The characteristics compared

The following characteristics derived from the MHWTS survey dataset were used: MHWTS respondents' age, sex, rank, service type, medical fitness for service, highest level of educational attainment, receipt of a Gold or White Card,⁷ psychological distress, depressive symptoms, anxiety, symptoms of posttraumatic stress disorder (PTSD), problematic anger, problem drinking, and suicidal thoughts/actions. Additionally, for those whose spouses/partners participated in the FWS, the percentage of MHWTS respondents who were not satisfied with their couple relationship is examined. This information is derived from MHWTS respondents, not FWS respondents, as we do not have data on these characteristics for family members who did not participate in the FWS. The measures used are summarised briefly below and described in more detail in Section 2.9.

⁷ A Gold Card entitles the holder to Department of Veterans' Affairs (DVA) funding for services for all clinically necessary healthcare needs, and all health conditions, whether they are related to war service or not. The card also entitles the holder to transport related to treatment of their accepted condition and access to the Repatriation Pharmaceutical Benefits Scheme. A White Card entitles the holder to care and treatment for: (a) accepted injuries or conditions that are war caused or service related; (b) malignant cancer, pulmonary tuberculosis, and any mental health condition, whether war caused or not; and (c) the symptoms of unidentifiable conditions that arise within 15 years of service (other than peacetime service). Services covered by a DVA White Card are the same as those for a Gold Card but must be for the above conditions. The card also entitles the holder to transport related to treatment of their accepted condition and access to the Repatriation Pharmaceutical Benefits Scheme.

Psychological distress was measured using the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002), a short screening questionnaire assessing psychological distress in the past four weeks. Those scoring in the 'high' or 'very high' range were classified as showing high psychological distress. PTSD symptoms in the past month were measured using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers, Litz, Herman, Huska, & Keane, 1993). A score of 40 or above was used to categorise respondents as showing high levels of PTSD symptoms. Suicidal thoughts, plans and attempts in the previous 12 months were measured using items developed for the MHWTS. For the analyses reported here, any report of suicidal thoughts, plans or attempts was used to classify respondents as showing suicidality; a criterion also used in the MHWTS. In addition, MHWTS participants also responded to items assessing depressive symptoms, measured using the Patient Health Questionnaire 9-item scale (PHQ-9) (Kroenke, Spitzer, & Williams, 2001), with a score of 15 or greater used to denote high levels of depression, the criterion used in the MHWTS. Anxiety symptoms were measured by the Generalised Anxiety Disorder 7-item scale (GAD-7) (Spitzer, Kroenke, Williams & Löwe, 2006), with a score of 12 or more being used to classify MHWTS respondents as having high levels of anxiety. Problematic anger was measured by the Dimensions of Anger Reactions 5-item scale (DAR-5) (Forbes et al., 2004). As in the study undertaken by the Centre for Traumatic Stress Studies, a score of 12 or greater was used to classify MHWTS respondents as showing problematic anger. Problem drinking was measured using the 10-item Alcohol Use Disorders Identification Test (AUDIT) (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993), with a score of 8 or more used to classify respondents as showing problem levels of alcohol use.

2.8.2 Differences between MHWTS respondents with and without any FWS data

Two samples were compared:

- a sample of MHWTS respondents who did not have any family member participate in the FWS
- a sample of MHWTS respondents who had one or more family members participate.

These samples were further divided by the Current Serving and Ex-Serving status of MHWTS respondents.

Table 2.4 shows that compared to Current Serving MHWTS respondents with no FWS data, their counterparts with FWS data were significantly more likely to be older, male (84.6% vs. 78.2%), have a university degree (45.4% vs. 35.1%), and be Commissioned Officers (53.4% vs. 40.4%). Non-commissioned Officers and those in other ranks were under-represented among Current Serving MHWTS respondents with FWS data.

Table 2.4 Characteristics of Current Serving MHWTS respondents with and without FWS data

Measure	No family members participated (n = 7,619)			1+ family member participated (n = 871)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.017
18 – < 28	557	7.5	(6.9 – 8.1)	46	5.3	(4.0 – 7.0)	
28 – < 38	2,232	29.9	(28.8 – 30.9)	254	29.3	(26.3 – 32.4)	
38 – < 48	2,671	35.7	(34.7 – 36.8)	306	35.3	(32.1 – 38.5)	
48 – < 58	1,828	24.5	(23.5 – 25.4)	247	28.5	(25.6 – 31.6)	
58+	186	2.5	(2.2 – 2.9)	15	1.7	(1.0 – 2.8)	
Missing	145			3			
Sex							0.000
Female	1,658	21.8	(20.8 – 22.7)	134	15.4	(13.1 – 17.9)	
Male	5,961	78.2	(77.3 – 79.2)	737	84.6	(82.1 – 86.9)	
Missing							
Rank							0.000
Commissioned Officer	3,078	40.4	(39.3 – 41.5)	465	53.4	(50.1 – 56.7)	
Non-commissioned Officer	3,967	52.1	(51.0 – 53.2)	372	42.8	(39.5 – 46.1)	
Other rank	573	7.5	(7.0 – 8.1)	33	3.8	(2.7 – 5.3)	
Missing	1			1			
Service type							0.734
Navy	1,824	23.9	(23.0 – 24.9)	218	25.0	(22.3 – 28.0)	
Army	3,155	41.4	(40.3 – 42.5)	351	40.3	(37.1 – 43.6)	
Air Force	2,640	34.7	(33.6 – 35.7)	302	34.7	(31.6 – 37.9)	
Missing							
Medical fitness for service							0.058
Fit	6,371	83.7	(82.8 – 84.5)	747	86.2	(83.7 – 88.3)	
Unfit	1,244	16.3	(15.5 – 17.2)	120	13.8	(11.7 – 16.3)	
Missing	4			4			
Highest level of education							0.000
Primary/secondary school	1,843	24.6	(23.7 – 25.6)	156	18.1	(15.6 – 20.8)	
Certificate/diploma	3,011	40.2	(39.1 – 41.4)	316	36.6	(33.4 – 39.8)	
University degree	2,627	35.1	(34.0 – 36.2)	392	45.4	(42.1 – 48.7)	
Missing	138			7			
DVA Gold or White Card	716	11.2	(10.4 – 12.0)	92	10.6	(8.7 – 12.9)	0.637
Psychological distress (K10)	1,209	16.6	(15.7 – 17.5)	137	15.7	(13.5 – 18.3)	0.529
Depressive symptoms (PHQ-9)	460	6.3	(5.7 – 6.9)	52	6.0	(4.6 – 7.8)	0.727
Generalised anxiety (GAD-7)	590	8.1	(7.5 – 8.7)	80	9.2	(7.4 – 11.3)	0.252
PTSD symptoms (PCL-C)	565	8.0	(7.4 – 8.7)	73	8.4	(6.8 – 10.5)	0.660
Problematic anger (DAR-5 ≥ 12)	951	13.1	(12.3 – 13.8)	122	14.1	(11.9 – 16.5)	0.409
Problem drinking (AUDIT ≥ 8)	1,355	19.4	(18.5 – 20.4)	155	17.8	(15.4 – 20.5)	0.267
Any suicidality	888	12.3	(11.5 – 13.1)	130	15.1	(12.8 – 17.6)	0.261

Note: 95% CI = 95% confidence interval.

There were no significant differences observed between Current Serving MHWTS respondents with and without FWS data on any mental health and wellbeing measures. Thus, there was no systematic trend for Current Serving MHWTS respondents of families participating in the FWS to be better, or more poorly, adjusted than their MHWTS counterparts whose family members did not participate.

Compared to the Ex-Serving sample of MHWTS respondents with no FWS data, their Ex-Serving counterparts with FWS data tended to be significantly older, male, and more highly educated (Table 2.5). Commissioned Officers were also over-represented among the Ex-Serving subgroup with FWS data (37.9% vs. 28.2%), while Non-commissioned Officers were under-represented, as were those in other ranks. Air Force families were also over-represented in the subgroup with FWS data, while the Army and Navy were slightly under-represented compared to the MHWTS sample with no FWS data.

There were no significant differences observed between Ex-Serving MHWTS respondents with and without FWS data on mental health and wellbeing characteristics.

2.8.3 Differences between MHWTS respondents with and without spouse/partner data

To investigate differences between MHWTS respondents with and without spouse/partner data, two samples were compared:

- a sample of MHWTS respondents who reported that they were in a couple relationship but did not have any family member participate in the FWS
- a sample of MHWTS respondents whose spouse/partner participated in the FWS.

As before, the groups were further divided by MHWTS respondents' serving status (Current Serving and Ex-Serving). Table 2.6 and Table 2.7 show comparisons of Current Serving and Ex-Serving MHWTS respondents with and without spouse/partner data.

Compared to the Current Serving sample of MHWTS respondents with no spouse/partner data, their counterparts with spouse/partner data were significantly more likely to be older, male, have higher educational levels, and be Commissioned Officers, although fewer were Non-commissioned Officers (Table 2.6). There were no significant differences by type of military service, but there was statistical evidence that Current Serving MHWTS respondents with spouse/partner data were less likely to be unfit for service compared to their parallel subgroup without spouse/partner data.

Table 2.5 Characteristics of Ex-Serving MHWTS respondents with and without FWS data

Measure	No family members participated (n = 3,909)			1+ family member participated (n = 428)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	446	11.6	(10.6 – 12.6)	25	5.8	(4.0 – 8.5)	
28 – < 38	1,152	29.9	(28.5 – 31.4)	112	26.2	(22.2 – 30.5)	
38 – < 48	1,011	26.2	(24.9 – 27.6)	113	26.4	(22.4 – 30.8)	
48 – < 58	768	19.9	(18.7 – 21.2)	105	24.5	(20.7 – 28.8)	
58+	477	12.4	(11.4 – 13.5)	73	17.1	(13.8 – 20.9)	
Missing	55			0			
Sex							0.035
Female	629	16.1	(15 – 17.3)	52	12.2	(9.4 – 15.6)	
Male	3,280	83.9	(82.7 – 85)	375	87.8	(84.4 – 90.6)	
Missing	0			1			
Rank							0.000
Commissioned Officer	1,103	28.2	(26.8 – 29.6)	162	37.9	(33.4 – 42.5)	
Non-commissioned Officer	1,904	48.7	(47.1 – 50.3)	197	46.0	(41.3 – 50.8)	
Other rank	902	23.1	(21.8 – 24.4)	69	16.1	(12.9 – 19.9)	
Service type							0.003
Navy	792	20.3	(19.0 – 21.6)	72	16.9	(13.6 – 20.7)	
Army	2,243	57.4	(55.8 – 58.9)	229	53.6	(48.9 – 58.3)	
Air Force	874	22.4	(21.1 – 23.7)	126	29.5	(25.4 – 34.0)	
Missing	0			1			
Medical fitness for service							0.723
Fit	2,687	68.8	(67.4 – 70.3)	294	69.7	(65.1 – 73.9)	
Unfit	1,217	31.2	(29.7 – 32.6)	128	30.3	(26.1 – 34.9)	
Missing	5			6			
Highest level of education							0.000
Primary/secondary school	932	24.2	(22.9 – 25.6)	76	17.8	(14.5 – 21.7)	
Certificate/diploma	1,844	47.9	(46.3 – 49.5)	198	46.4	(41.7 – 51.1)	
University degree	1,074	27.9	(26.5 – 29.3)	153	35.8	(31.4 – 40.5)	
Missing	59			1			
DVA Gold or White Card	1,548	50.6	(48.8 – 52.3)	233	55.3	(50.6 – 60.0)	0.066
Psychological distress (K10)	1,196	32.4	(30.9 – 33.9)	144	33.8	(29.5 – 38.4)	0.559
Depressive symptoms (PHQ-9)	698	18.8	(17.6 – 20.1)	85	20.0	(16.4 – 24.0)	0.566
Generalised anxiety (GAD-7)	797	21.5	(20.2 – 22.9)	108	25.4	(21.5 – 29.8)	0.068
PTSD symptoms (PCL-C)	859	24.6	(23.2 – 26.0)	115	27.1	(23.0 – 31.5)	0.264
Problematic anger (DAR-5 ≥ 12)	1,027	27.9	(26.4 – 29.3)	126	29.6	(25.5 – 34.2)	0.440
Problem drinking (AUDIT ≥ 8)	1,101	32.0	(30.4 – 33.6)	153	36.1	(31.6 – 40.8)	0.088
Any suicidality	1,069	29.1	(27.7 – 30.6)	140	33.0	(28.7 – 37.6)	0.095

Note: 95% CI = 95% confidence interval.

Table 2.6 Characteristics of Current Serving MHWTS respondents with and without spouse/partner data

Measure	No spouse/partner participated (n = 6,405)			Spouse/partner participated (n = 675)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	384	6.1	(5.5 – 6.7)	22	3.3	(2.2 – 4.9)	
28 – < 38	1,868	29.7	(28.5 – 30.8)	173	25.7	(22.5 – 29.1)	
38 – < 48	2,295	36.4	(35.3 – 37.6)	253	37.6	(34.0 – 41.3)	
48 – < 58	1,596	25.3	(24.3 – 26.4)	212	31.5	(28.1 – 35.1)	
58+	155	2.5	(2.1 – 2.9)	13	1.9	(1.1 – 3.3)	
Missing	107			2			
Sex							0.000
Female	1,217	19.0	(18.1 – 20.0)	57	8.4	(6.6 – 10.8)	
Male	5,188	81.0	(80.0 – 81.9)	618	91.6	(89.2 – 93.4)	
Missing							
Rank							0.000
Commissioned Officer	2,704	42.2	(41.0 – 43.4)	358	53.1	(49.3 – 56.9)	
Non-commissioned Officer	3,299	51.5	(50.3 – 52.7)	294	43.6	(39.9 – 47.4)	
Other rank	401	6.3	(5.7 – 6.9)	22	3.3	(2.2 – 4.9)	
Missing	1			1			
Service type							0.913
Navy	1,521	23.7	(22.7 – 24.8)	162	24.0	(20.9 – 27.4)	
Army	2,654	41.4	(40.2 – 42.6)	274	40.6	(36.9 – 44.3)	
Air Force	2,230	34.8	(33.7 – 36)	239	35.4	(31.9 – 39.1)	
Missing							
Medical fitness for service							0.035
Fit	5,405	84.5	(83.5 – 85.3)	589	87.5	(84.8 – 89.8)	
Unfit	995	15.5	(14.7 – 16.5)	84	12.5	(10.2 – 15.2)	
Missing	5			2			
Highest level of education							0.000
Primary/secondary school	1,471	23.0	(22.0 – 24.1)	118	17.6	(14.9 – 20.7)	
Certificate/diploma	2,610	40.8	(39.6 – 42.0)	243	36.3	(32.7 – 40.0)	
University degree	2,313	36.2	(35.0 – 37.4)	309	46.1	(42.4 – 49.9)	
Missing	11						
DVA Gold or White Card	640	11.8	(10.9 – 12.7)	75	11.1	(9.0 – 13.8)	0.635
Psychological distress {K10}	955	15.5	(14.6 – 16.4)	104	15.4	(12.9 – 18.4)	0.975
Depressive symptoms {PHQ-9}	361	5.8	(5.3 – 6.4)	39	5.8	(4.3 – 7.8)	0.970
Generalised anxiety {GAD-7}	484	7.8	(7.2 – 8.5)	64	9.5	(7.5 – 12.0)	0.127
PTSD symptoms {PCL-C}	446	7.5	(6.8 – 8.2)	58	8.6	(6.7 – 11.0)	0.279
Problematic anger {DAR-5 ≥ 12}	813	13.2	(12.4 – 14.0)	91	13.5	(11.1 – 16.3)	0.803
Problem drinking {AUDIT ≥ 8}	1,108	18.8	(17.8 – 19.8)	115	17.1	(14.4 – 20.1)	0.291
Any suicidality	674	11.0	(10.2 – 11.8)	100	15.0	(12.5 – 17.9)	0.002
Dissatisfaction with couple relationship	1,107	19.7	(18.6 – 20.7)	111	16.6	(13.9 – 19.6)	0.056

Note: 95% CI = 95% confidence interval.

Table 2.7 **Characteristics of Ex-Serving MHWTS respondents with and without spouse/partner data**

Measure	No spouse/partner participated (n = 3,130)			Spouse/partner participated (n = 306)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	275	8.9	(0.5 – 7.9)	7	2.3	(1.1 – 4.7)	
28 – < 38	883	28.6	(0.8 – 27.0)	72	23.5	(19.1 – 28.6)	
38 – < 48	852	27.6	(0.8 – 26.0)	82	26.8	(22.1 – 32.1)	
48 – < 58	655	21.2	(0.7 – 19.8)	88	28.8	(24.0 – 34.1)	
58+	424	13.7	(0.6 – 12.6)	57	18.6	(14.6 – 23.4)	
Missing	41			0			
Sex							0.001
Female	454	14.5	(4.3 – 9.9)	20	6.5	(84.2 – 86.7)	
Male	2,675	85.5	(13.3 – 15.8)	286	93.5	(90.1 – 95.7)	
Missing	1			0			
Rank							0.003
Commissioned Officer	962	30.7	(29.1 – 32.4)	118	38.6	(33.3 – 44.1)	
Non-commissioned Officer	1,558	49.8	(48.0 – 51.5)	148	48.4	(42.8 – 54.0)	
Other rank	610	19.5	(18.1 – 20.9)	40	13.1	(9.7 – 17.3)	
Missing							
Service type							0.031
Navy	624	19.9	(18.6 – 21.4)	45	14.7	(11.2 – 19.1)	
Army	1,775	56.7	(55.0 – 58.5)	174	56.9	(51.2 – 62.3)	
Air Force	730	23.3	(21.9 – 24.8)	87	28.4	(23.6 – 33.8)	
Missing	1			0			
Medical fitness for service							0.928
Fit	2,208	70.7	(69.1 – 72.2)	212	70.4	(65.0 – 75.3)	
Unfit	916	29.3	(27.8 – 30.9)	89	29.6	(24.7 – 35.0)	
Missing	6			5			
Highest level of education							0.024
Primary/secondary school	693	22.2	(20.8 – 23.7)	48	15.7	(12.1 – 20.3)	
Certificate/diploma	1,490	47.7	(45.9 – 49.4)	151	49.5	(43.9 – 55.1)	
University degree	941	30.1	(28.5 – 31.8)	106	34.8	(29.6 – 40.3)	
Missing	6			1			
DVA Gold or White Card	1,292	51.7	(49.8 – 53.7)	166	55.1	(49.5 – 60.7)	0.261
Psychological distress (K10)	888	29.7	(28.1 – 31.3)	106	34.8	(29.6 – 40.3)	0.066
Depressive symptoms (PHQ-9)	508	16.9	(15.6 – 18.3)	64	21.0	(16.8 – 25.9)	0.073
Generalised anxiety (GAD-7)	613	20.5	(19.1 – 21.9)	82	27.0	(22.3 – 32.3)	0.008
PTSD symptoms (PCL-C)	648	22.8	(21.3 – 24.4)	85	27.9	(23.1 – 33.2)	0.048
Problematic anger (DAR-5 ≥ 12)	820	27.5	(25.9 – 29.1)	94	30.9	(26.0 – 36.4)	0.201
Problem drinking (AUDIT ≥ 8)	839	30.0	(28.3 – 31.7)	113	37.2	(31.9 – 42.8)	0.010
Any suicidality	770	25.9	(24.4 – 27.5)	98	32.2	(27.2 – 37.7)	0.017
Dissatisfaction with couple relationship	555	21.1	(19.6 – 22.7)	70	23.0	(18.6 – 28.1)	0.446

Note: 95% CI = 95% confidence interval.

There were no significant differences observed between Current Serving MHWTS respondents with and without spouse/partner data on mental health and wellbeing characteristics, except for rates of any type of suicidality (thoughts, plans or attempts). The rate was higher among Current Serving MHWTS respondents whose spouses/partners participated in the FWS than those whose spouses/partners did not participate.

As found for comparisons of Current Serving groups with and without spouse/partner data, the Ex-Serving MHWTS respondents with spouse/partner data were significantly more likely to be older, male, and Commissioned Officers compared to their Ex-Serving counterparts (Table 2.7). There were no significant differences by military service or medical fitness for service.

Some differences were observed between Ex-Serving MHWTS respondents with and without spouse/partner data on mental health and wellbeing. Significant differences were found in the areas of PTSD symptoms, levels of anxiety, problem drinking and suicidality, with these being higher among Ex-Serving MHWTS respondents whose spouses/partners participated in the FWS than those whose spouses/partners did not participate.

2.8.4 Differences between MHWTS respondents with and without parent data

To investigate differences between MHWTS respondents with and without parent data, two samples were compared, with the samples further subdivided by the serving status of MHWTS respondents (Current Serving or Ex-Serving):

- a sample of MHWTS respondents who did not have any family member participate (it was assumed that every MHWTS respondent had a parent)
- a sample of MHWTS respondents whose parent participated in the FWS.

Table 2.8 and Table 2.9 report on these comparisons for Current Serving and Ex-Serving MHWTS respondents, respectively.

Compared to Current Serving MHWTS respondents with no parent data, those with parent data were significantly more likely to be younger, female, have a university degree, be Commissioned Officers (although fewer were Non-commissioned Officers), and not be in receipt of a DVA Gold or White Card (Table 2.8). There were no significant differences by the type of military service or medical fitness.

No significant differences were observed between Current Serving MHWTS respondents with and without parent data on any mental health and wellbeing characteristics.

Table 2.8 **Characteristics of Current Serving MHWTS respondents with and without parent data**

Measure	No parent participated (n = 8,330)			1+ parent participated (n = 160)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	578	7.1	(6.5 – 7.6)	25	15.7	(10.8 – 22.3)	
28 – < 38	2,406	29.4	(28.4 – 30.4)	80	50.3	(42.6 – 58.0)	
38 – < 48	2,930	35.8	(34.8 – 36.9)	47	29.6	(23.0 – 37.1)	
48 – < 58	2,068	25.3	(24.3 – 26.2)	7	4.4	(2.1 – 9.0)	
58+	201	2.5	(2.1 – 2.8)	0	0.0	(0.0 – 0.0)	
Missing	147			1			
Sex							0.000
Female	1,726	20.7	(19.9 – 21.6)	66	41.3	(33.9 – 49.1)	
Male	6,604	79.3	(78.4 – 80.1)	94	58.8	(50.9 – 66.1)	
Missing	0						
Rank							0.001
Commissioned Officer	3,453	41.5	(40.4 – 42.5)	99	56.3	(48.4 – 63.8)	
Non-commissioned Officer	4,276	51.3	(50.3 – 52.4)	53	39.4	(32.1 – 47.2)	
Other rank	599	7.2	(6.7 – 7.8)	7	4.4	(2.1 – 8.9)	
Missing	2			0			
Service type							0.588
Navy	1,998	24.0	(23.1 – 24.9)	44	27.5	(21.1 – 34.9)	
Army	3,443	41.3	(40.3 – 42.4)	63	39.4	(32.1 – 47.2)	
Air Force	2,889	34.7	(33.7 – 35.7)	53	33.1	(26.3 – 40.8)	
Missing	0			0			
Medical fitness for service							0.596
Fit	6,987	83.9	(83.1 – 84.7)	131	82.4	(75.6 – 87.6)	
Unfit	1,336	16.1	(15.3 – 16.9)	28	17.6	(12.4 – 24.4)	
Missing	7			1			
Highest level of education							0.020
Primary/secondary school	1,972	24.1	(23.2 – 25.0)	27	17.0	(11.9 – 23.7)	
Certificate/diploma	3,268	39.9	(38.9 – 41.0)	59	37.1	(29.9 – 44.9)	
University degree	2,946	36.0	(35.0 – 37.0)	73	45.9	(38.3 – 53.7)	
Missing	144			1			
DVA Gold or White Card	804	11.3	(10.6 – 12.1)	< 5	2.6	(1.0 – 6.7)	0.001
Psychological distress (K10)	1,323	16.5	(15.7 – 17.4)	23	14.4	(9.7 – 20.7)	0.466
Depressive symptoms (PHQ-9)	505	6.3	(5.8 – 6.8)	7	4.4	(2.1 – 8.9)	0.323
Generalised anxiety (GAD-7)	657	8.2	(7.6 – 8.8)	13	8.1	(4.8 – 13.5)	0.976
PTSD symptoms (PCL-C)	628	8.1	(7.5 – 8.7)	10	6.4	(3.5 – 11.5)	0.433
Problematic anger (DAR-5 ≥ 12)	1,049	13.1	(12.4 – 13.9)	24	15.1	(10.3 – 21.6)	0.466
Problem drinking (AUDIT ≥ 8)	1,480	19.2	(18.4 – 20.1)	30	18.8	(13.4 – 25.6)	0.875
Any suicidality	995	12.5	(11.8 – 13.3)	23	14.4	(9.7 – 20.7)	0.487

Note: 95% CI = 95% confidence interval.

Table 2.9 Characteristics of Ex-Serving MHWTS respondents with and without parent data

Measure	No parent participated (n = 4,248)			1+ parent participated (n = 89)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	456	10.9	(10.0 – 11.9)	15	16.9	(10.4 – 26.2)	
28 – < 38	1,222	29.1	(27.8 – 30.5)	42	47.2	(37.0 – 57.6)	
38 – < 48	1,096	26.1	(24.8 – 27.5)	28	31.5	(22.6 – 41.9)	
48 – < 58	870	20.7	(19.5 – 22.0)	< 5	3.4	(1.1 – 10.0)	
58+	549	13.1	(12.1 – 14.1)	< 5	1.1	(0.2 – 7.6)	
Missing	55			0			
Sex							0.000
Female	655	15.4	(14.4 – 16.5)	26	29.5	(20.9 – 39.9)	
Male	3,593	84.6	(83.5 – 85.6)	62	70.5	(60.1 – 79.1)	
Missing	0			1			
Rank							0.280
Commissioned Officer	1,240	29.2	(27.8 – 30.6)	25	28.1	(19.7 – 38.3)	
Non-commissioned Officer	2,063	48.6	(47.1 – 50.1)	38	42.7	(32.8 – 53.2)	
Other rank	945	22.2	(21.0 – 23.5)	26	29.2	(20.7 – 39.5)	
Service type							0.201
Navy	840	19.8	(18.6 – 21.0)	24	27.3	(19.0 – 37.5)	
Army	2,428	57.2	(55.7 – 58.6)	44	50.0	(39.6 – 60.4)	
Air Force	980	23.1	(21.8 – 24.4)	20	22.7	(15.1 – 32.7)	
Medical fitness for service							0.882
Fit	2,921	68.9	(67.5 – 70.3)	60	68.2	(57.7 – 77.1)	
Unfit	1,317	31.1	(29.7 – 32.5)	28	31.8	(22.9 – 42.3)	
Missing	10			1			
Highest level of education							0.045
Primary/secondary school	983	23.5	(22.2 – 24.8)	25	28.1	(19.7 – 38.3)	
Certificate/diploma	2,011	48.0	(46.5 – 49.5)	31	34.8	(25.6 – 45.3)	
University degree	1,194	28.5	(27.2 – 29.9)	33	37.1	(27.7 – 47.6)	
Missing	60			0			
DVA Gold or White Card	1,740	51.2	(49.6 – 52.9)	41	47.7	(37.3 – 58.2)	0.514
Psychological distress {K10}	1,312	32.6	(31.1 – 34.0)	28	31.8	(22.9 – 42.3)	0.883
Depressive symptoms {PHQ-9}	765	18.9	(17.7 – 20.1)	18	20.5	(13.2 – 30.2)	0.711
Generalised anxiety {GAD-7}	883	21.9	(20.6 – 23.2)	12	25.0	(17.0 – 35.1)	0.483
PTSD symptoms {PCL-C}	953	24.9	(23.5 – 26.3)	21	23.9	(16.1 – 33.9)	0.829
Problematic anger {DAR-5 ≥ 12}	1,125	28.0	(26.6 – 29.4)	28	31.8	(22.9 – 42.3)	0.427
Problem drinking {AUDIT ≥ 8}	1,219	32.2	(30.8 – 33.8)	35	40.2	(30.4 – 50.9)	0.116
Any suicidality	1,177	29.4	(28.0 – 30.8)	32	36.4	(27.0 – 46.9)	0.155

Note: 95% CI = 95% confidence interval.

Similarly, the Ex-Serving MHWTS respondents with parent data were significantly more likely to be younger, female and have achieved higher educational levels (Table 2.9). There were no significant differences by other service-related characteristics.

There were also no significant differences observed between Ex-Serving MHWTS respondents with and without parent data on mental health and wellbeing characteristics.

2.8.5 Differences between MHWTS respondents with and without adult child data

To investigate differences between MHWTS respondents with and without adult child data, two samples were compared:

- a sample of MHWTS respondents who reported that they had at least one adult child but who did not have any family member participate
- a sample of MHWTS respondents who had at least one adult child participate in the FWS.

These samples were further subdivided by the Current Serving and Ex-Serving status of MHWTS respondents, and are reported in Table 2.10 and Table 2.11 respectively.

Compared to Current Serving MHWTS respondents without adult child data, those with adult child data were significantly more likely to be older (Table 2.10). There were no significant differences by other service-related characteristics.

There were also no significant differences observed between Current Serving MHWTS respondents with and without adult child data on mental health and wellbeing characteristics.

Similar differences were observed for Ex-Serving MHWTS respondents with and without adult child data (Table 2.11). Compared to those without adult child data, Ex-Serving MHWTS respondents with adult child data were likely to be older and have a university degree. Commissioned Officers were also over-represented in the Ex-Serving MHWTS sample with adult child data, while Non-commissioned Officers were under-represented. There were no significant differences by other service-related characteristics.

There were also no significant differences between Ex-Serving MHWTS respondents with and without adult child data on mental health and wellbeing characteristics.

Table 2.10 Characteristics of Current Serving MHWTS respondents with and without adult child data

Measure	No adult children participated (n = 2,063)			1+ adult child participated (n = 51)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	0	0.0	(0.0 – 0.0)	0	0.0	(0.0 – 0.0)	
28 – < 38	22	1.1	(0.7 – 1.6)	< 5	2.0	(0.3 – 12.9)	
38 – < 48	590	28.9	(27.0 – 30.9)	7	13.7	(6.6 – 26.3)	
48 – < 58	1,267	62.0	(59.9 – 64.1)	40	78.4	(64.9 – 87.7)	
58+	164	8.0	(6.9 – 9.3)	< 5	5.9	(1.9 – 16.9)	
Missing	20			0			
Sex							0.802
Female	220	10.7	(9.4 – 12.1)	6	11.8	(5.3 – 24.0)	
Male	1,843	89.3	(87.9 – 90.6)	45	88.2	(76.0 – 94.7)	
Missing	0			0			
Rank							0.436
Commissioned Officer	829	40.2	(38.1 – 42.3)	25	49.0	(35.6 – 62.6)	
Non-commissioned Officer	1,196	58.0	(55.9 – 60.1)	25	49.0	(35.6 – 62.6)	
Other rank	37	1.8	(1.3 – 2.5)	< 5	2.0	(0.3 – 12.9)	
Missing	1			0			
Service type							0.658
Navy	461	22.3	(20.6 – 24.2)	10	19.6	(10.8 – 32.9)	
Army	879	42.6	(40.5 – 44.8)	25	49.0	(35.6 – 62.6)	
Air Force	723	35.0	(33.0 – 37.1)	16	31.4	(20.1 – 45.4)	
Missing	0			0			
Medical fitness for service							0.683
Fit	1,684	81.7	(80.0 – 83.4)	42	84.0	(71.0 – 91.9)	
Unfit	376	18.3	(16.6 – 20.0)	8	16.0	(8.1 – 29.0)	
Missing	3			0			
Highest level of education							0.409
Primary/secondary school	544	26.4	(24.6 – 28.4)	9	18.0	(9.6 – 31.3)	
Certificate/diploma	888	43.1	(41.0 – 45.3)	24	48.0	(34.5 – 61.8)	
University degree	627	30.5	(28.5 – 32.5)	17	34.0	(22.2 – 48.2)	
Missing	4			1			
DVA Gold or White Card	407	21.9	(20.1 – 23.8)	15	29.4	(18.5 – 43.4)	0.201
Psychological distress {K10}	354	17.5	(15.9 – 19.3)	7	13.7	(6.6 – 26.3)	0.478
Depressive symptoms {PHQ-9}	150	7.4	(6.4 – 8.6)	6	11.8	(5.3 – 24.0)	0.245
Generalised anxiety {GAD-7}	187	9.3	(8.1 – 10.6)	< 5	5.9	(1.9 – 16.9)	0.410
PTSD symptoms {PCL-C}	195	9.9	(8.6 – 11.3)	5	9.8	(4.1 – 21.6)	0.990
Problematic anger {DAR-5 ≥ 12}	224	11.1	(9.8 – 12.6)	7	13.7	(6.6 – 26.3)	0.558
Problem drinking {AUDIT ≥ 8}	353	18.0	(16.4 – 19.8)	6	11.8	(5.3 – 24.0)	0.249
Any suicidality	260	13.0	(11.6 – 14.5)	8	16.0	(8.1 – 29.0)	0.528

Note: 95% CI = 95% confidence interval.

Table 2.11 Characteristics of Ex-Serving MHWTS respondents with and without adult child data

Measure	No adult children participated (n = 1,176)			1+ adult children participated (n = 44)			p-value
	n	%	(95% CI)	n	%	(95% CI)	
Age (years)							0.000
18 – < 28	0	0.0	(0.0 – 0.0)	0	0.0	(0.0 – 0.0)	
28 – < 38	7	0.6	(0.3 – 1.3)	0	0.0	(0.0 – 0.0)	
38 – < 48	194	16.6	(14.6 – 18.9)	8	18.2	(9.3 – 32.6)	
48 – < 58	522	44.7	(41.9 – 47.6)	17	38.6	(25.4 – 53.8)	
58+	444	38.0	(35.3 – 40.9)	19	43.2	(29.3 – 58.2)	
Missing	9			0			
Sex							0.725
Female	90	7.7	(6.3 – 9.3)	< 5	9.1	(3.4 – 22.1)	
Male	1,086	92.3	(90.7 – 93.7)	40	90.9	(77.9 – 96.6)	
Missing							
Rank							0.002
Commissioned Officer	519	44.1	(41.3 – 47.0)	20	63.6	(48.4 – 76.5)	
Non-commissioned Officer	616	52.4	(49.5 – 55.2)	12	27.3	(16.1 – 42.3)	
Other rank	41	3.5	(2.6 – 4.7)	< 5	9.1	(3.4 – 22.1)	
Missing	0			0			
Service type							0.079
Navy	205	17.4	(15.4 – 19.7)	< 5	9.1	(3.4 – 22.1)	
Army	611	52.0	(49.1 – 54.8)	20	45.5	(31.4 – 60.3)	
Air Force	60	30.6	(28.0 – 33.3)	20	45.5	(31.4 – 60.3)	
Missing	0			0			
Medical fitness for service							0.322
Fit	828	70.6	(67.9 – 73.1)	28	63.6	(48.4 – 76.5)	
Unfit	345	29.4	(26.9 – 32.1)	16	36.4	(23.5 – 51.6)	
Missing	3			0			
Highest level of education							0.009
Primary/secondary school	266	22.7	(20.4 – 25.2)	5	11.4	(4.8 – 24.8)	
Certificate/diploma	523	44.6	(41.8 – 47.4)	15	34.1	(21.6 – 49.3)	
University degree	384	32.7	(30.1 – 35.5)	24	54.5	(39.7 – 68.6)	
Missing	3			0			
DVA Gold or White Card	651	63.0	(60.0 – 65.9)	30	68.2	(53.0 – 80.3)	0.487
Psychological distress (K10)	328	28.8	(26.3 – 31.5)	13	29.5	(17.9 – 44.7)	0.917
Depressive symptoms (PHQ-9)	187	16.4	(14.4 – 18.7)	8	18.2	(9.3 – 32.6)	0.759
Generalised anxiety (GAD-7)	207	18.2	(16.1 – 20.6)	9	20.5	(10.9 – 35.1)	0.709
PTSD symptoms (PCL-C)	258	23.3	(20.9 – 25.8)	11	25.0	(14.3 – 39.9)	0.789
Problematic anger (DAR-5 ≥ 12)	253	22.3	(20.0 – 24.8)	9	20.5	(10.9 – 35.1)	0.774
Problem drinking (AUDIT ≥ 8)	297	26.8	(24.3 – 29.5)	9	20.5	(10.9 – 35.1)	0.348
Any suicidality	312	27.6	(25.0 – 30.2)	15	34.9	(22.1 – 50.3)	0.293

Note: 95% CI = 95% confidence interval.

2.8.6 Summary

Table 2.12 shows the demographic and service-related characteristics on which MHWTS respondents with various types of FWS data significantly differed from corresponding MHWTS respondents without parallel FWS data, summarised from the data presented earlier in Tables 2.3 to 2.10. With few exceptions, results were similar for MHWTS respondents who were Current Serving or Ex-Serving. Therefore, the summary presented in Table 2.12 combines the findings for these MHWTS respondents (although we note below the table when findings differed).

Table 2.12 Demographic and service factors on which MHWTS respondents with and without different types of FWS data significantly differed

MHWTS respondents characteristic	Any FWS data	Spouse/partner data	Parent data	Adult child data
Age	Older	Older	Younger	Older
Sex	More males	More males	More females	–
Service rank*	More were COs Fewer were NCOs Fewer were Other	More were COs	More were COs# Fewer were NCOs	More were COs+ Fewer were NCOs
Service type	–†	–†	–	–
Education	Higher levels	Higher levels	Higher levels	Higher levels§
Medical fitness for service	–	Fewer unfit‡	–	–
DVA Gold or White Card	–	–	Fewer had a card^	–

* COs = Commissioned Officers; NCOs = Non-commissioned Officers; Other = Other Rank.

† The Air Force was over-represented and the Army under-represented in the Ex-Serving group with family data. The Air Force was over-represented and the Navy under-represented in the Ex-Serving group with spouse/partner data.

‡ No significant differences on medical fitness for Ex-Serving groups with spouse/partner data.

No significant differences on rank between Ex-Serving spouse/partner groups.

^ No significant differences on whether a Gold or White Card was held between Ex-Serving parent groups.

+ No significant differences on rank between Current Serving adult children data.

§ No significant differences on education between Current Serving adult children data.

Note: A dash (–) indicates no significant difference on this characteristic.

Results tended to be similar for MHWTS respondents with any family FWS data, spouse/partner data or adult child data. Thus, MHWTS respondents with FWS data tended to be older, male, contain a higher proportion of Commissioned Officers and fewer Non-commissioned Officers, and be more highly educated. Like other MHWTS respondents with FWS data, those with parent data also tended to contain more Commissioned Officers and fewer Non-commissioned Officers, and be more highly educated, but they also tended to be younger and contain more females. The few differences by service type were only evident for Ex-Serving MHWTS respondents with any family or spouse/partner data, with the Air Force tending to be over-represented. There were also some factors on which only one comparison was significant (medical fitness, possession of a DVA Gold or White Card).

These findings are consistent with those of Section 2.4 in suggesting that the sample recruited to the FWS may be somewhat biased towards families in which MHWTS

respondents held higher ranks, were more highly educated, and were older. Thus, the FWS findings are likely to be particularly relevant to families of serving members with these characteristics, but may be less pertinent to families in which serving members hold more junior ranks, are younger or less educated. Also, as noted in Section 2.4, bias may be introduced if these characteristics themselves contribute to and influence the results. These limitations may affect the generalisability of the FWS findings.

However, it is important to note that with the one exception discussed below, there were no significant differences on a range of mental health and problem behaviour indicators when comparing MHWTS respondents whose family members took part in the FWS and those whose family members did not take part. Thus, they did not significantly differ on levels of depression, psychological distress, generalised anxiety, PTSD symptoms, suicidality, problematic anger or problem drinking. These findings suggest that there was no systemic trend for the MHWTS respondents of the families participating in the FWS to be better (or more poorly) adjusted or to differ on engagement in risk-taking. Thus, the findings suggest that FWS families are relatively representative in terms of their MHWTS respondents' psychosocial health and wellbeing.

Only the comparison of MHWTS respondents who had, or did not have, spouse/partner data revealed significant differences on mental health and risk-taking indicators. Both Current Serving and Ex-Serving MHWTS respondents with participating spouses/partners were found to have higher rates of suicidality. Also, Ex-Serving MHWTS respondents with participating spouses/partners were found to be higher on generalised anxiety, PTSD symptoms, and risky drinking, suggesting that this subgroup of MHWTS respondents may have been more vulnerable in these areas. As these serving member characteristics are known to affect spouses/partners, as indicated by considerable prior research (see Chapter 1), FWS findings for the spouses/partners of Ex-Serving MHWTS respondents are likely to be affected to a certain degree.

Summing up, the analyses undertaken in Section 2.8 suggest there is a certain amount of bias in the demographic and service-related characteristics of MHWTS respondents with FWS data, but there was generally no bias on their psychosocial characteristics.

2.9 Measures used in Part 1

This last section of Chapter 2 summarises the MHWTS respondent and FWS participant measures reported on in Part 1. Where possible, the measures selected had been used in other studies of military families and populations, or were respected, widely used measures from general population studies. A key consideration was to use the same measures as the MHWTS survey to increase comparability across members of the same families. The broad domains covered were: demographic characteristics, living

arrangements, employment circumstances, ADF service details and impact, within-family wellbeing, involvement in risk-taking, mental and physical health, and help seeking and pathways to care. The source of the measures is described in each subsection, while scoring details, data treatments, and any cut-offs used are provided in the accompanying tables.

In chapters 3, 4 and 5, for ease of communication, military members who participated in the MHWTS are referred to as ‘ADF members’ (although it is recognised that some are Ex-Serving and thus are technically no longer members of the ADF). Therefore, from now on we refer to ‘MHWTS respondents’ as ‘ADF members’.

2.9.1 Demographic characteristics

ADF members and FWS participants provided information (Table 2.13) about their sex, date of birth and highest educational level/qualification achieved. These items were taken from *2010 Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report* (McFarlane et al., 2011).

Table 2.13 Demographic characteristics

Variable name	Item details	How used in the analyses
ADF MEMBERS AND FWS PARTICIPANTS		
Age	Date of birth	Five age categories: 1 = 18 – < 28; 2 = 28 – < 38; 3 = 38 – < 48; 4 = 48 – < 58; 5 = 58+
Sex	Participants indicated their sex.	1 = female; 2 = male
Highest educational qualification	Participants reported the highest educational level/qualification they had completed using 7 options: 1 = primary school; 2 = secondary school (up to Grade 10); 3 = secondary school (Grades 11–12); 4 = certificate (trade, apprenticeship, technicians, etc.); 5 = diploma; 6 = bachelor university degree; 7 = postgraduate university qualification.	Recoded into three categories: 1 = Primary/secondary school (codes 1–3) 2 = Certificate/diploma (codes 4–5) 3 = University degree (codes 6–7)
FWS PARTICIPANTS		
Indigenous status	Do you identify as Aboriginal or Torres Strait Islander?	0 = no; 1 = yes
Relationship to ADF member	FWS participant indicated how they were related to their ADF member using 5-response categories 1 = Spouse/partner nominated; 2 = Ex-spouse/ex-partner nominated; 3 = Parent nominated; 4 = Child aged 18+ nominated; 5 = Other.	Categories 1 and 2 were subsequently combined for statistical analyses, or those in category 2 were sometimes dropped as appropriate.
Has a child with ADF member	Spouses/partners and ex-spouses/ex-partners were asked if they had any children with ADF member (including biological, step or adopted children).	0 = no; 1 = yes

Further demographic information was also obtained from FWS participants regarding their Indigenous status (item from the Vietnam Veterans Family Study; Forrest et al., 2014), how they were related to their ADF members (study-developed item), and whether they had a child with their ADF member (as used in the MHWTS survey).

2.9.2 Living arrangements, being without a permanent place to live, and mobility

FWS participants completed items regarding their own and their ADF members' living arrangements (Table 2.14). Participants reported on the distance of their ADF members' residence from their home, an item adapted from the Australian Temperament Project, 2010; Vassallo & Sanson, 2013). They also reported on the number of people living in their own household and the length of time they had lived in their current household, along with the number of house and school moves undertaken. These items were developed by the Australian Institute of Family Studies for the FWS. Experiences of being without a permanent place to live were also measured using eight items from the 2010 Australian Bureau of Statistics (ABS) General Social Survey (Australian Bureau of Statistics, 2011).

2.9.3 Employment circumstances and financial hardship

FWS participants completed a number of items regarding their employment circumstances and experience of financial hardship (Table 2.15). They responded to items measuring their current employment status (adapted from the Australian Temperament Project; Vassallo & Sanson, 2013), length of current employment, and periods of leave of six months or more (these items were developed for the purposes of the FWS). FWS participants' experience of financial hardship was measured using items adapted from the Australian Temperament Project 2014–15 survey (Vassallo & Sanson, 2013).

Table 2.14 Living arrangements and experiences of being without a permanent place to live

Variable	Item and scale details	How used in the analyses
ADF member's household type	FWS participant indicated which household type best described their ADF member's household. Eleven response options (e.g. person living alone, single parent with dependent child(ren)).	Six categories: 1 = person living alone; 2 = couple living alone; 3 = couple with child(ren); 4 = married with dependants unaccompanied*; 5 = single parent with child(ren); 6 = other household type
Distance of ADF member's home from family member	FWS participant indicated where their ADF member lived in relation to them (e.g. in the same household, less than 1 kilometre away). Eight response options were provided.	Subsequently recoded into 5 categories: 1 = In same household; 2 = Less than 25 kilometres away; 3 = Between 25 and 100 kilometres away; 4 = Between 100 and 500 kilometres away; 5 = More than 500 kilometres away
Number of people living in FWS participant's household	FWS participant indicated the number of people living in their current household.	Five categories: 1 = 1 person; 2 = 2 people; 3 = 3 people; 4 = 4 people; 5 = 5+ people
Length of time FWS participant has lived in current household	FWS participant provided the date they first moved into current household address.	Seven categories: 1 = ≤ 1 year; 2 = 2 years; 3 = 3 years; 4 = 4 years; 5 = 5–9 years; 6 = 10–19 years; 7 = 20+ years
Being without a permanent place to live		
Ever without a permanent place to live	FWS participant indicated whether they have ever had any of the listed experiences because they did not have a permanent place to live (e.g. slept rough, stayed in a night shelter). Ten items.	A dichotomous score was formed, with 0 = no to all items; 1 = yes to any item
Number of times without a permanent place to live	FWS participant indicated how many times they were without a permanent place to live. Six options.	Four categories: 1 = 1 time; 2 = 2 times; 3 = 3 times; 4 = 4+ times (combining 4 times and 5+ times)
When last without a permanent place to live	FWS participant indicated when their most recent experience of being without a permanent place to live was (e.g. less than 12 months ago). Five response options.	Five categories: 1 = < 1 year ago; 2 = 1 – < 2 years ago; 3 = 2 – < 5 years ago; 4 = 5 – < 10 years ago; 5 = 10+ years ago
Last time, how long without a permanent place to live	FWS participants indicated, for their most recent experience, how long they had been without a permanent place to live (e.g. one week to less than two weeks). Nine response options.	Recoded into three categories: 1 = < 1 month; 2 = 1 – < 6 months; 3 = 6+ months
Reasons for being without a permanent place to live	FWS participant selected from a list what led to them being without a permanent place to live (e.g. saving money, mental illness). Thirteen reasons.	For each of 13 reasons: 0 = no; 1 = yes
Mobility		
Number of places lived during ADF member's service	FWS participant reported how many places lived during ADF members and their own ADF service. Two items.	Six categories: 1 = ≤ 2 places; 2 = 3–4 places; 3 = 5–6 places; 4 = 7–8 places; 5 = 9–10 places; 6 = 11+
Number of moves due to ADF member's service	Participant reported how many moves were due to ADF member's service and their own ADF service. Two items.	Five categories: 1 = no moves; 2 = 1–2 moves; 3 = 3–4 moves; 4 = 5–6 moves; 5 = 7+ moves
Number of places lived after ADF member transitioned from service	FWS participant reported how many places were lived after their ADF member / they had transitioned from ADF service. Two items.	Three categories: 1 = 0–1 places; 2 = 2 places; 3 = 3+ places
Reason for most recent move	Twenty-two options provided, e.g. work transfer, military posting, to be closer to friends/family.	All response options used
Number of schools attended during ADF member's service	Single question – FWS participant provided the number of schools.	Recoded into 1 = 1 school; 2 = 2 schools; 3 = 3 schools; 4 = 4 schools; 5 = 5 schools; 6 = 6+ schools
Number of schools attended after ADF member transitioned	Single question – FWS participant provided the number of schools.	Recoded into 1 = 1 school; 2 = 2 schools; 3 = 3+ schools

* 'Married with dependants unaccompanied' refers to ADF members who are married and have dependent children but are living separately for service-related reasons (e.g. they have been posted to a new location but their families are living in their former location).

Table 2.15 Employment circumstances and financial hardship

Variable	Item and scale details	How used in the analyses
Current employment status	FWS participant indicated whether they were currently working (yes/no), and if yes, whether that work was full-time or part-time. Two items.	Three categories: 1 = Working full-time; 2 = Working part-time; 3 = Not working
Length of current employment	FWS participant reported the year in which they started working in their current employment.	Number of years in current employment, six categories: 1 = ≤ 1 year; 2 = 2–4 years; 3 = 5–9 years; 4 = 10–14 years; 5 = 15–19 years; 6 = 20+ years
Periods of leave of 6 months or longer in current job	For duration of current employment, participant indicated whether their employment had been continuous or if there were periods of leave. Yes – the work was continuous; No – there were periods of leave for 6 months or more.	0 = no; 1 = yes
Main source of income	FWS participant indicated their main source of income (e.g. paid employment). Nine response options.	Recoded into six categories: 1 = Paid employment; 2 = Self-employment; 3 = Spouse's/partner's income; 4 = Parent's financial support; 5 = Government allowance; 6 = Other
Financial hardship	FWS participant indicated if they had experienced eight different types of financial hardships in the last 2 years because of a shortage of money (e.g. could not pay electricity, gas or telephone bills on time; went without meals). Eight items.	For each item: 0 = no; 1 = yes A financial hardship index was developed, with 0 = no financial hardships; 1 = one financial hardship; and 2 = two or more financial hardships were experienced.

2.9.4 ADF service details

ADF members completed a range of items regarding their current military status, rank, main service type, and years served (Table 2.16). These items were drawn from the ABS (Australian Bureau of Statistics, 2008) and the 2011 Australian Defence Force Exit Survey (Shirt, 2012). ADF members' Medical Employment Classification status was obtained from the Military and Veteran Research Study Roll, which classified them as 'fit' (employable and deployable) or 'unfit' (not fit for deployment). MHWTS participants also provided information about their deployment history (e.g. country deployed to, name of the operation, dates deployed, number of times deployed, total months deployed, and whether deployed in combat capacity), with deployments including warlike/active service, non-warlike (including peacekeeping) service, humanitarian/disaster relief, Defence aid to civil communities, and border protection. Deployment was measured using items adapted from the *2010 Mental health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing StudyFull report* (McFarlane et al., 2011). Lifetime exposure to trauma was also measured, using the posttraumatic stress disorder module of the Composite International Diagnostic Interview Version 3.0 (Haro et al., 2006).

FWS participants provided information regarding their ADF members' and their own ADF military service. This included details of deployment, sharing of deployment experiences, feelings of connectedness to the ADF, and the impact of military service on ADF members and their families. These items were adapted from the MHWTS survey.

Table 2.16 Military service characteristics and impact of service

Variable	Item and scale details	How used in the analyses
MHWTS PARTICIPANTS		
Military status	ADF members indicated whether they were currently an ADF reservist. Four response options: Yes, I am an active reservist; Yes, I am an active reservist on continuous full-time service; Yes, I am an inactive reservist; No, I have discharged from the ADF.	Combined with other Programme data, four categories were derived: 1 = Currently serving; 2 = Active reservist; 3 = Inactive reservist; 4 = Discharged from ADF
Rank	ADF members indicated their rank. Five response options: 1 = Senior Commissioned Officer (CMDR / LTCOL / WGCDR and above); 2 = Commissioned Officer (LCDR / MAJ / SQNLDR and below); 3 = Senior Non-commissioned Officer (PO / SGT and above); 4 = Junior Non-commissioned Officer (LS / CPL and below); 5 = Other ranks (AB / SMN / PTE / LAC / AC and equivalent).	Three categories were derived: 1 = Commissioned Officer (codes 1–2); 2 = Non-commissioned Officer (codes 3–4); 3 = Other ranks
Main service	ADF members indicated their service. Three response options: Navy; Army; Air Force.	Three categories: 1 = Navy; 2 = Army; 3 = Air Force
Medical fitness for service	Classification extracted from the Military and Veteran Research Study Roll, with 'fit' = employable and deployable; and 'unfit' = not fit for deployment.	0 = Fit; 1 = Unfit.
Years in regular, full-time ADF service	ADF members indicated the number of years served in the regular, full-time ADF.	Number of years
Amount of time in regular, full-time ADF service	ADF members indicated the number of years served in the regular, full-time ADF.	Six categories: 1 = < 4 years; 2 = 4 – < 8 years; 3 = 8 – < 12 years; 4 = 12 – < 16 years; 5 = 16 – < 20; 6 = 20+ years
Deployment	ADF members indicated whether they had ever deployed to any of the listed operations (e.g. Afghanistan, East Timor).	Lifetime deployment: 0 = no; 1 = yes
Lifetime trauma exposures	ADF members indicated whether they had experienced any of 26 traumatic events (e.g. being a peacekeeper in a war zone or a place of ongoing terror; having someone close to you die).	For each trauma, 0 = no, 1 = yes Number of trauma exposures: 0 = 0 traumas, 1 = 1 trauma; 2 = 2 traumas; 3 = 3 traumas, 4 = 4+ traumas
FWS PARTICIPANTS		
ADF member ever deployed	FWS participant indicated whether their ADF member had ever deployed.	0 = no; 1 = yes
Together during deployment	FWS participant indicated whether they were together as a couple when their ADF member was on deployment.	0 = no; 1 = yes
Deployment experience shared	FWS participant indicated how much their ADF member has shared his/her deployment experiences with the FWS participant. Four-point scale: 1 = none to 4 = a lot.	Four categories: 0 = No; 1 = A little; 2 = Somewhat; 3 = A lot
FWS participant is a Current Serving or Ex-Serving ADF member	FWS participant indicated whether they are or were a member of the ADF.	0 = no; 1 = yes
FWS participant was ever deployed	FWS participant who was or had been an ADF member indicated whether they had ever been deployed.	0 = no; 1 = yes
Parent was in ADF	FWS participant indicated whether one or both parents served in the ADF.	0 = no; 1 = yes
Impact of military experiences		
On ADF member	FWS participant rated how negative or positive their ADF member's military service experiences had been on ADF member's relationships (e.g. with spouse, children), mental health, physical health, employment, financial situation, and career. Six-point scale: 1 = extremely negative to 6 = extremely positive. Eleven items.	For each item, three categories: 1 = negative (codes 1–2); 2 = no influence (code 3); 3 = positive (codes 4–5)

Variable	Item and scale details	How used in the analyses
On FWS participant	FWS participant rated how negative or positive their ADF member's military service experiences have been on the FWS participant's own relationships (e.g. with spouse, children), mental health, physical health, employment, financial situation, and career. Six-point scale: 1 = extremely negative to 6 = extremely positive. Eleven items.	For each item, three categories: 1 = negative (code 1–2); 2 = no influence (code 3); 3 = positive (codes 4–5)
Impact of FWS participant's own military service on themselves	FWS participant rated how negative or positive their own military service experiences had been on their own relationships (e.g. with spouse, children), mental health, physical health, employment, financial situation, and career. Six-point scale: 1 = extremely negative to 6 = extremely positive. Eleven items.	For each item, three categories: 1 = negative (code 1–2); 2 = no influence (code 3); 3 = positive (codes 4–5)

2.9.5 Within-family wellbeing

Questions about couple relationships were only asked of FWS participants and ADF members who were currently in a spouse/partner relationship (Table 2.17). ADF members' satisfaction with their relationship with their spouse/partner was measured using a single item taken from the Household, Income and Labour Dynamics in Australia (HILDA) Survey (Watson & Wooden, 2002). FWS participating spouses'/partners' happiness in the relationship was assessed using a single global item from the Abbreviated Dyadic Adjustment Scale (Sharpley & Rodgers, 1984). Relationship quality was measured using the 7-item Relationship Assessment Scale (Hendrick, 1988). Intimate partner violence was measured using the Woman Abuse Screening Tool (Brown, Lent, Schmidt, & Sas, 2000), used in the Vietnam Veterans Family Study and the MHWTS survey.

If FWS spouses/partners had children with their ADF members, they were asked about their parenting practices and how well they thought they were going as a parent (Table 2.18). Four core parenting practices were assessed: consistency (how consistent parents were when disciplining their children), angry/hostile parenting (the extent to which parents used aversive or harsh discipline), inductive reasoning (how often parents explained the reasons behind rules or why a child was being corrected), and warmth (how often parents showed pleasure when interacting with their child and enjoyed their child's company). Parental self-efficacy reflected how well parents thought they were fulfilling their parenting role. The measures were derived from the Longitudinal Study of Australian Children (warmth, inductive reasoning) (Gray & Sanson, 2005), the National Longitudinal Study of Children and Youth (consistency) (Statistics Canada, 2000) and the Early Childhood Longitudinal Study of Children (hostility, parental self-efficacy) (National Center for Education Statistics, 2001).

Table 2.17 Couple relationships

Variable	Item and scale details	How used in the analyses
Unhappy relationship	FWS spouses/partners rated the degree of happiness, all things considered, in their relationship using a 7-point scale, with 1 = extremely unhappy to 7 = perfectly happy.	Recoded into 0 = Happy (a score of 3–7); and 1 = Unhappy (a score of 1–2)
Relationship quality	FWS spouses/partners rated aspects of their relationship using 5-point scales tailored to the item content (e.g. how well does your spouse/partner meet your needs; how good is your relationship compared to most).	The mean of the items is computed after reverse scoring two negatively oriented items.
Relationship satisfaction	ADF members rated how satisfied or dissatisfied they were with their relationship with their spouse/partner using a 10-point scale, with 0 = completely dissatisfied to 10 = completely satisfied.	Recoded into 0 = Unsatisfied (a score of 1–6), and 1 = Satisfied (a score of 7–10)
Abuse in the couple relationship	FWS spouses/partners reported whether their ADF member had behaved in an emotionally or physically abusive way using 8 items (e.g. do arguments ever result in hitting, kicking or pushing?). Three response options were provided: 1 = never to 3 = often.	A total score was computed (the sum of the 8 items). This was subsequently dichotomised into 0 = there had not been abuse in the relationship (a score of 0–16) and 1 = there had been abuse in the relationship (a score of 17–24).

Table 2.18 Parenting practices and parental self-efficacy

Variable	Item and scale details	How used in the analyses
Consistency	FWS spouses/partners rated how often they displayed consistent parenting behaviours (e.g. when you give the child an instruction or request to do something, how often do you make sure he/she does it; how often does the child get away with things that you feel should have been punished?). Five items with five response options: 1 = never / almost never; 2 = less than half the time; 3 = about half the time; 4 = more than half the time; 5 = all the time.	The mean of the items is computed, first recoding three items assessing inconsistency.
Anger/hostility	FWS spouses/partners rated how often they displayed anger or hostility when interacting with their child (e.g. how often are you angry when you punish the child?). Six items with five response options: 1 = never / almost never; 2 = less than half the time; 3 = about half the time; 4 = more than half the time; 5 = all the time.	The mean of the items is computed, first reverse coding one item.
Inductive reasoning	FWS spouses/partners rated how often they used inductive reasoning with their child (e.g. talk it over and reason with the child when he/she misbehaves). Five items with five response options: 1 = never / almost never; 2 = rarely; 3 = sometimes; 4 = often; 5 = always / almost always.	The mean of the items is computed.
Warmth	FWS spouses/partners rated how often they expressed affection for their child, felt close to them, and had warm and intimate times with the child (e.g. I enjoy listening to the child and doing things with him/her). Six items with five response options: 1 = never / almost never; 2 = rarely; 3 = sometimes; 4 = often; 5 = always / almost always.	The mean of the items is computed.
Parenting self-efficacy	FWS spouses/partners: Overall, as a parent, do you feel you are: 1 = not very good at being a parent; 2 = a person who has some trouble being a parent; 3 = an average parent; 4 = a better-than-average parent; 5 = a very good parent.	The single score is used.

If one or more child was aged between 2 and 17 years, FWS spouses/partners were also asked to report on a selected child's behaviour during the past six months (Table 2.19). This child was randomly selected during MHWTS data collection using the following process. ADF members with one or more dependent children were asked about the number of dependent children they were living with, and an algorithm was then used to randomly select one child whom they reported on for the MHWTS. The same child was reported on by spouses/partners for the FWS. The 25-item Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1995) was used to assess child behaviour problems. The SDQ has slightly different versions for children aged 2 to 4 years, 5 to 10 years and 11 to 17 years to ensure that the items used are developmentally appropriate. The SDQ contains scales measuring conduct problems, emotional symptoms, hyperactivity, peer problems and prosocial behaviour. A 'total behaviour problems' score is also derived.

Table 2.19 Child behaviour problems and competencies

Variable	Item and scale details	How used in the analyses
Conduct problems	FWS spouses/partners rated whether various aggressive or antisocial behaviours had occurred in the past 6 months (e.g. often fights with other children or bullies them; often lies or cheats). Five items with three response options: 0 = not true; 1 = somewhat true; 2 = certainly true.	A total conduct problems score is created. Using the norms provided, cut-offs identify children showing abnormally high levels of conduct problems.
Emotional symptoms	FWS spouses/partners rated whether children had shown various anxious, withdrawn or emotionally upset behaviours in the past 6 months (e.g. many worries, often seems worried; often unhappy, depressed or tearful). Five items with three response options: 0 = not true; 1 = somewhat true; 2 = certainly true.	A total emotional symptoms score is created. Using the norms provided, cut-offs are used to identify children showing abnormally high levels of emotional symptoms.
Hyperactivity	FWS spouses/partners rated whether various hyperactive, distractible, or poor attention span behaviours had occurred in the past 6 months (e.g. restless, overactive, cannot stay still for long; easily distracted, concentration wanders). Five items with three response options: 0 = not true; 1 = somewhat true; 2 = certainly true.	A total hyperactivity score is created. Using the norms provided, cut-offs identify children showing abnormally high levels of hyperactivity.
Peer problems	FWS spouses/partners rated whether children had experienced peer problems or were socially isolated in the past 6 months (e.g. picked on or bullied by other children; rather solitary, prefers to play alone). Five items with three response options: 0 = not true; 1 = somewhat true; 2 = certainly true.	A total peer problems score is created. Using the norms provided, cut-offs identify children showing abnormally high levels of peer problems.
Prosocial behaviour	FWS spouses/partners rated whether children had been kind, helpful or cooperative when interacting with others in the past 6 months (e.g. shares readily with other children, for example, toys, treats, pencils; generally well behaved, usually does what adults request). Five items with three response options: 0 = not true; 1 = somewhat true; 2 = certainly true.	A total prosocial behaviour score is created. Using the norms provided, cut-offs identify children showing abnormally low levels of prosocial behaviour.
Total behaviour problems	The conduct problems, emotional symptoms, hyperactivity and peer problems scores were summed.	A total behaviour problems score is created. Using the norms provided, cut-offs identify children showing abnormally high levels of total behaviour problems.

2.9.6 Involvement in risk-taking

ADF members and FWS participants responded to a number of items measuring their involvement in risk-taking (Table 2.20). Alcohol use, including frequency of alcohol consumption, binge drinking and risky drinking, was measured using the 10-item Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993). Gambling, including engagement in gambling activities and gambling severity, was measured using the Problem Gambling Severity Index (Volberg & Williams, 2012; Miller, Currie, Hodgins, & Casey, 2013). Illicit drug use, including 12-month and lifetime use, was measured using items adapted from the 2013 National Drug Strategy Survey (Australian Institute of Health and Welfare, 2014). As illicit drug use is officially banned and leads to instant dismissal among current serving ADF members, illicit drug use was assessed only for Ex-Serving ADF members and all FWS participants who were not Current Serving ADF members.

Table 2.20 Involvement in risk-taking

Variable	Item and scale details	How used in the analyses
ADF MEMBERS AND FWS PARTICIPANTS		
Problem drinking	Participants responded to items regarding quantity and frequency of alcohol consumption, symptoms of dependence, and reactions or problems related to alcohol. Five-point scale: 0 = never to 4 = daily or almost daily. Ten items.	Two measures were derived: 1 Total score (sum of 10 items) 2 Problem drinking: 0 = no (scores < 8); 1 = yes (scores ≥ 8)
Illicit drug use	Ex-serving ADF members and FWS participants who were not currently in the ADF indicated whether they had used any of the listed drugs (e.g. marijuana, heroin) in (1) the last 12 months and (2) in their lifetime. Two items.	For last 12 months and lifetime use: 0 = no; 1 = yes
FWS PARTICIPANTS		
Gambling in the last 12 months	FWS participants indicated whether, in the last 12 months, they spent money on any of eight gambling activities, e.g. bingo, poker, betting on sports. For each activity: no, yes.	Any instance of gambling: 0 = no instances; 1 = 1+ instances
Gambling severity	FWS participants who reported any instance of gambling rated whether they had experienced gambling-related problems (e.g. bet more than you could really afford to lose; borrowed money or sold something to get money to gamble). Four-point scale: 0 = never to 3 = almost always. Nine items.	Two measures were derived: 1 Severity: total score (sum of 9 items) 2 Gambling problem: 0 = no instances (score = 0); 1 = yes, 1+ instances (score > 0)

2.9.7 Mental and physical health

MHWTS and FWS participants completed a range of items measuring their mental and physical health (Table 2.21). Psychological distress was measured using the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002), a short screening questionnaire widely used in general populations. Posttraumatic stress disorder (PTSD) symptoms were measured using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers et al., 1993). Suicidal thoughts, plans and attempts were measured using items from the MHWTS survey. ADF members also reported on depressive symptoms using the Patient Health Questionnaire 9-item scale (PHQ-9) (Kroenke et al., 2001), generalised anxiety using the Generalised Anxiety Disorder

7-item scale (GAD-7) (Spitzer et al., 2006), and problematic anger using the Dimensions of Anger Reactions 5-item scale (DAR-5) (Forbes et al., 2004).

FWS participants and ADF members reported on their physical health. In Part 1, the self-reported general health rating, obtained using an item from the Short Form 36 Health Survey (Ware & Sherbourne, 1992), is used. Quality of life was measured using a single item adapted from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015).

FWS participants also responded to a range of additional items relating to their own mental and physical health, and that of their ADF members. This included measures of mental health concerns, using items developed for the MHWTS survey. Participants' experience of traumatic events in their lifetime was measured using items from the MHWTS survey.

Table 2.21 Mental and physical health, traumatic events, concerns about mental health

Variable	Item and scale details	How used in the analyses
ADF MEMBERS AND FWS PARTICIPANTS		
Psychological distress	ADF members and FWS participants rated how often they had experienced a range of symptoms over the last four weeks (e.g. felt tired, nervous, hopeless). Five-point scale: 1 = none of the time to 5 = all of the time. The scale contains 10 items. In 2014–15, 11.7% of a representative sample of Australians were classified as showing high or very high psychological distress on the K10 (ABS, 2015). This is similar to the rate of 10.8% of persons receiving a diagnosis of an affective or depressive disorder in the Australian 2007 National Survey of Mental Health and Wellbeing (Slade et al., 2009). Thus, the FWS classification is likely to identify individuals suffering significant mental health problems.	Total score (mean of 10 items) was taken and two measures were derived: Four categories: 1 = low (< 16) 2 = moderate (≥ 16 and < 22) 3 = high (≥ 22 and < 30) 4 = very high (≥ 30) High psychological distress: 0 = no/moderate psychological distress (< 22) 1 = high/very high psychological distress (≥ 22)
Posttraumatic stress disorder (PTSD) symptoms	If FWS participants had experienced a traumatic event in their lifetime, they rated how much they had been bothered by symptoms of PTSD in the past month (e.g. repeated, disturbing memories, thoughts or images of a stressful experience from the past). Five-point scale: 1 = not at all to 5 = extremely. Seventeen items. All ADF members responded to the above items assessing PTSD symptoms.	Total score (sum of 17 items) was taken. Levels of PTSD symptoms were classified as: 0 = low/moderate symptoms (< 40) 1 = high/very high symptoms (≥ 40) The cut-offs are the same as in MHWTS.
Suicidality	ADF members and FWS participants indicated if, in the last 12 months, they had experienced suicidal ideation, made a suicide plan and/or attempt. For each item: no, yes. Four items.	Over the four items assessed, any instance of suicidality: 0 = no; 1 = yes
Made a plan or attempted suicide	ADF members and FWS participants: a suicide plan or attempt had been made in the last 12 months. For each item: no, yes. Two items.	Any plan or attempt: 0 = no; 1 = yes
Physical health	ADF members and FWS participants rated their physical health over the last year. Five-point scale: 1 = very poor to 5 = excellent.	Subsequently recoded as: 0 = average or good physical health (> 2) 1 = poor physical health (≤ 2)

Variable	Item and scale details	How used in the analyses
Quality of life	FWS participants rated their current quality of life. Five-point scale: 1 = very poor to 5 = very good.	Subsequently recoded as: 0 = average or good quality of life (> 2) 1 = poor quality of life (≤ 2)
Lifetime traumatic events	ADF members and FWS participants indicated whether they had experienced any of the listed traumatic events in their lifetime (e.g. been sexually assaulted; been mugged, held up or threatened with a weapon). They were asked to check all that applied, and to specify other types of traumas experienced. Eleven events.	Total number of traumatic events experienced. Five categories were derived: 0 = none; 1 = 1; 2 = 2; 3 = 3; 4 = 4+
ADF MEMBERS		
Depressive symptoms	ADF members rated their depressive symptoms over the last two weeks (e.g. little interest or pleasure in doing things, feeling down, depressed, or hopeless). Four-point scale: 0 = not at all to 3 = nearly every day. Nine items.	Total score (sum of 9 items) was taken. Five categories: Minimal levels (0–4) Mild levels (5–9) Moderate levels (10–14) Moderately severe levels (15–19) Severe levels (20–27) Presence of depression: 0 = no/moderate levels (0–14) 1 = moderately severe/severe levels (≥ 15) The cut-offs are the same as in MHWTS.
Generalised anxiety	ADF members rated how often they had been bothered by anxiety symptoms over the last two weeks (e.g. felt nervous, anxious or on edge; worrying too much about different things). Four-point scale: 0 = not at all to 3 = nearly every day. Seven items.	Total score (sum of 7 items) was taken. Minimal levels (0–4) Mild levels (5–9) Moderate levels (10–14) Severe levels (15–21) Presence of anxiety: 0 = no/moderate levels (0–9) 1 = moderately severe/severe levels (≥ 10) The cut-offs are the same as in MHWTS.
Problematic anger	ADF members rated the amount of time they had experienced each symptom of anger (e.g. when I got angry, I got really mad; when I got angry, I stayed angry) over the past four weeks. Five-point scale ranging from 1 = none of the time to 5 = all of the time. Five items.	Total score (sum of 5 items) was taken. Presence of problematic anger: 0 = no/low levels (1–11) 1 = problematic levels (≥ 12) The cut-offs are the same as in MHWTS.
FWS PARTICIPANTS		
Concerns about own mental health	FWS participants indicated whether they had ever been concerned about their own mental health.	0 = no; 1 = yes
Length of concern about own mental health	If concerns, date when FWS participant first became concerned about their own mental health.	Number of years was derived. Seven categories: 1 = ≤ 1 year; 2 = 2 years; 3 = 3 years; 4 = 4 years; 5 = 5–9 years; 6 = 10–19; 7 = 20+ years
Concerns about ADF member's mental health	FWS participants indicated whether they had ever been concerned about ADF member's mental health.	0 = no; 1 = yes
Length of concern about ADF member's mental health	If concerns, date when FWS participant first became concerned about ADF member's mental health.	Number of years was derived. Six categories: 1 = ≤ 1 year; 2 = 2 years; 3 = 3 years; 4 = 4 years; 5 = 5–9 years; 6 = 10+ years

2.9.8 Help seeking and pathways to care

FWS participants responded to a range of items measuring help seeking and pathways to care for their own mental health problems, and their ADF members' mental health problems (Table 2.22). For their own mental health problems, participants provided information on whether and when they had sought help, if they knew where to get help, if a family member provided assistance, the problems that led them to seek help, and which self-help strategies they had used.

Table 2.22 Help seeking and pathways to care for mental health problems

Variable	Item and scale details	How used in the analyses
REGARDING FWS PARTICIPANTS		
First sought help for own mental health problems	FWS participants indicated if and when they sought help after becoming concerned about their own mental health. Four response options (e.g. within 3 months of becoming concerned).	Four categories: 1 = within 3 months of becoming concerned; 2 = within 1 year of becoming concerned; 3 = more than 1 year after becoming concerned; 4 = did not seek help
Last sought help for own mental health problems	FWS participants indicated whether they had ever received assistance for their own mental health. Four response options.	Four categories: 1 = currently seeking help; 2 = not currently, but in last 12 months; 3 = not currently, but 12+ months ago; 4 = never sought help
Knew where to get help for their own mental health problems	FWS participants indicated whether they knew where to get help for their own mental health.	0 = no; 1 = yes
Family member contacted someone to get help for them	FWS participants indicated whether a family member contacted someone to get help for participant.	0 = no; 1 = yes
Problems that led FWS participants to seek help for themselves	FWS participants specified the main problem that had led them to seek help for themselves (e.g. depression, anxiety). Select one from list or specify other.	11 problems: anger; anxiety; relationship problems; nightmares; depression; alcohol or drug problems; sleep; pain; problems at work; gambling; other. For each, 0 = no; 1 = yes
Mental health condition diagnosed/treated by a medical doctor	FWS participants indicated whether they had any of the listed mental health conditions diagnosed and/or treated by a medical doctor (1) in their lifetime, and (2) in the last 12 months (e.g. alcohol abuse or dependency, depression). Select all that apply, specify other. Two items.	Five conditions for both lifetime and last 12 months: alcohol abuse or dependency; anxiety or stress; depression; PTSD; or other psychiatric/psychological condition needing treatment/counselling. For each, 0 = no; 1 = yes.
Self-reported mental health conditions not diagnosed/treated by a medical doctor	FWS participants indicated problems/conditions they had experienced that had not been diagnosed or treated (e.g. alcohol abuse or dependency, anxiety or stress). Select all that apply, specify other.	Five conditions: alcohol abuse or dependency; anxiety or stress; depression; PTSD; or other psychiatric/psychological condition needing treatment/counselling. For each, 0 = no; 1 = yes.
Use of self-help strategies	FWS participants indicated whether they had used any of 34 services to inform/assess their own mental health in the last 12 months (e.g. ADF website, Headspace website, self-help group).	For each item: 0 = no; 1 = yes
Barriers and stigmas to receiving care	FWS participants rated their agreement with reasons why they did not seek help (e.g. preferred to manage myself, didn't think anything could help). Five-point scale: 1 = strongly disagree to 5 = strongly agree. Seven items.	Each item recoded to: 0 = no (disagree / strongly disagree, neutral); 1 = yes (agree / strongly agree)

Variable	Item and scale details	How used in the analyses
REGARDING ADF MEMBERS		
Provided assistance for ADF member mental health	FWS participants indicated whether they had ever provided assistance to their ADF members for their mental health. Four response options (e.g. yes, currently).	Four categories: 1 = currently providing assistance; 2 = not currently, but in last 12 months; 3 = not currently, but 12+ months ago; 4 = never provided assistance
Assistance included encouraging ADF member to get help for their mental health	FWS participants indicated whether the assistance provided to ADF members for their mental health included encouragement to seek help.	0 = no; 1 = yes
Who did they suggest ADF member could get help from	FWS participants indicated who they encouraged their ADF members to seek help from (e.g. from GP / medical officer, partner, friend). Select all that apply, specify other.	Nine sources of help: GP / medical officer; partner; other family member; friend; colleague; supervisor / manager / commander; counsellor / mental health professional; telephone service (e.g. Lifeline or MensLine); other
Did ADF member seek help after encouragement	FWS participants indicated whether ADF members sought help after encouragement from participants.	0 = no; 1 = yes
Did ADF member know where to get help	FWS participants indicated whether ADF members knew where to get help.	0 = no; 1 = yes
Did family member contact anyone to get help for ADF member	FWS participants contacted someone to get help for ADF members.	0 = no; 1 = yes
Who did they contact on behalf of ADF member	FWS participants indicated who they contacted to get help for ADF members (e.g. GP / medical officer, friend). Select all that apply, specify other.	Eight sources of help: GP / medical officer; other family member; friend; colleague; supervisor / manager / commander; counsellor / mental health professional; telephone service (e.g. Lifeline or MensLine); other
Problems that led FWS participants to encourage ADF members to seek help	FWS participants specified the problem that led them to encourage ADF members to seek help (e.g. anger, anxiety). Select one from list or specify other.	Eleven problems: anger; anxiety; relationship problems; nightmares; depression; alcohol or drug problems; sleep; pain; problems at work; gambling; other. For each, 0 = no; 1 = yes.
Mental health condition was diagnosed/treated by a medical doctor	FWS participants indicated whether ADF members had any of the listed mental health conditions diagnosed and/or treated by a medical doctor in the last 12 months (e.g. alcohol abuse or dependency, depression). Select all that apply, specify other.	Four conditions for both lifetime and last 12 months: alcohol abuse or dependency; anxiety or stress; depression; PTSD; or other psychiatric/psychological condition needing treatment/counselling. For each, 0 = no; 1 = yes.

Regarding their ADF members' mental health, FWS participants provided information on whether they provided assistance to ADF members to seek help, whether and where help was sought, and problems that led them to encourage their ADF members to seek help. These items were adapted from the *2010 Mental health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study: Full report* (McFarlane et al., 2011) and items used in the MHWTS survey. FWS participants also reported on ADF members' mental health conditions diagnosed/treated by a medical doctor, measured using items adapted from the Australian Gulf War Veterans Health Study 2011 follow-up (Sim et al., 2015) and used in the MHWTS.

Finally, FWS participants reported on barriers and stigma they had experienced in seeking care for their own mental health problems, measured using items adapted from the 2010 ADF Mental Health Prevalence and *Wellbeing Study: Full report* (McFarlane et al., 2011), the Canadian Armed Forces Recruit Mental Health Service Use

Questionnaire (Fikretoglu, Blais, & Lam, 2014), the Solider Wellbeing Survey (Riviere et al., 2011; Thomas et al., 2010), and items developed by the Centre for Traumatic Stress Studies.

3 Health and wellbeing of FWS military families

Chapter 3 reports on levels of physical, mental, social and economic wellbeing among all Family Wellbeing Study (FWS) participants, and then separately for the various participating subgroups: spouses/partners, adult children, and parents. In reading these results, it is important to remember that because Mental Health and Wellbeing Transition Study (MHWTS) respondents whose families participated in the FWS were not completely representative of the wider Programme population from which they were derived, caution is needed when generalising study findings beyond the FWS sample.

For ease of communication, from now on military members who participated in the MHWTS are referred to as ‘ADF members’, although it is recognised that some are Ex-Serving and thus are technically no longer members of the ADF. Most of the results presented in this chapter utilise FWS survey data; however, there are instances when survey data from the MHWTS are used. Where this occurs, we note the source of the data as being the MHWTS.

3.1 Meet the families

This section provides an overview of all individuals who participated in the FWS (‘FWS participants’ or ‘family members’). It describes their demographic characteristics (e.g. age, sex, education, living arrangements, employment), how they were related to their ADF members, the military service history of FWS participants themselves and ADF members, and the impact of military service on ADF members and on their civilian FWS family members. For FWS participants who are or have been ADF members, the impact of ADF service on their own relationships and personal functioning is examined.

3.1.1 Method

Sample

This section uses the complete family data sample (Sample 1 – see Chapter 2) comprising the 1,387 family members who had complete data for key demographic and background variables (military status of ADF member, and FWS respondents’ age, sex, highest level of education, and relationship to ADF member) and had responses to at least 50% of the 38 survey questions which were asked of all respondents. All participating family members are included in this section: spouses, partners, ex-spouses, ex-partners, parents, adult children and people who described their relationship to ADF members as ‘other’.

Statistical analysis

Summary statistics are provided for all family members, and stratified by the serving status of ADF members (Current Serving or Ex-Serving). For categorical measures, percentages have been calculated, with the difference between family members of Current Serving and Ex-Serving ADF members tested using the chi-square test or Fisher's exact test. The latter test was used if an expected cell count was fewer than five people. For continuous measures, the mean and standard deviation were calculated and differences tested using *t*-tests. All tests were two-sided and *p*-values are included in the tables so that the strength of the evidence of a statistically significant difference between the two groups can be assessed. We have interpreted *p*-values of ≤ 0.05 as providing sufficient evidence of a difference. Where cell sizes are fewer than five, the actual number has been replaced in the tables by < 5 for confidentiality reasons.

3.1.2 Background characteristics

Demographic characteristics

Table 3.1 presents demographic characteristics for all FWS participants.

Looking first at FWS participants' age, the smallest age group was 18 to 27 years (7.6%), while the largest age groups were 38 to 47 and 48 to 57 years (26.4% and 25.4% respectively). A further 22.0% were 28 to 37 years, and 18.5% were 58 years or older. Family members of Ex-Serving ADF members tended to be significantly older when compared to family members of Current Serving ADF members (e.g. 49.6% were aged 48 years or older compared with 41.2% of those with Current Serving ADF members).

More than four in five FWS participants were female (85.3%). The FWS sample tended to be highly qualified, with 42.7% having attained a university degree, 34.2% a certificate or diploma, and 23.0% a primary or secondary school qualification. Only 1.0% of all FWS participants self-identified as being Indigenous. There were no statistically significant differences between family members of Current Serving or Ex-Serving ADF members on their sex, highest level of education achieved, or Indigenous status.

The majority of FWS participants were the spouses/partners of their ADF members (69.4%), 1.5% were ex-spouses/ex-partners, 19.8% were their parents, 7.3% were their adult offspring and 1.9% were 'other'. There were significantly more spouses/partners and fewer adult children in the participating families of Current Serving ADF members than the families of Ex-Serving ADF members.

Table 3.1 Demographics of FWS participants, stratified by ADF members' military status

Characteristic	Military status of ADF member							p-value
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Age (years)								0.00
18 – < 28	7.6	72	7.8	(6.2 – 9.7)	34	7.4	(5.3 – 10.2)	
28 – < 38	22.0	202	21.7	(19.2 – 24.5)	103	22.5	(18.9 – 26.6)	
38 – < 48	26.4	272	29.3	(26.4 – 32.3)	94	20.5	(17.1 – 24.5)	
48 – < 58	25.4	234	25.2	(22.5 – 28.1)	119	26.0	(22.2 – 30.2)	
58+	18.5	149	16.0	(13.8 – 18.5)	108	23.6	(19.9 – 27.7)	
Sex								0.18
Female	85.3	784	84.4	(81.9 – 86.6)	399	87.1	(83.7 – 89.9)	
Male	14.7	145	15.6	(13.4 – 18.1)	59	12.9	(10.1 – 16.3)	
Highest level of education								0.17
Primary/secondary school	23.0	202	21.7	(19.2 – 24.5)	117	25.5	(21.7 – 29.8)	
Certificate/diploma	34.2	331	35.6	(32.6 – 38.8)	144	31.4	(27.3 – 35.9)	
University degree	42.7	396	42.6	(39.5 – 45.8)	197	43.0	(38.5 – 47.6)	
Indigenous*	1.0	11	1.2	(0.7 – 2.1)	< 5	0.7	(0.2 – 2.0)	0.36
Relationship to ADF member								0.02
Spouse/partner	69.4	662	71.3	(68.3 – 74.1)	300	65.5	(61.0 – 69.7)	
Ex-spouse	1.5	15	1.6	(1.0 – 2.7)	6	1.3	(0.6 – 2.9)	
Parent	19.8	182	19.6	(17.2 – 22.3)	93	20.3	(16.9 – 24.3)	
Adult children aged 18+	7.3	54	5.8	(4.5 – 7.5)	48	10.5	(8.0 – 13.6)	
Other	1.9	16	1.7	(1.1 – 2.8)	11	2.4	(1.3 – 4.3)	

* Given the extremely small number of Indigenous participants, this characteristic is not included in later analyses.

Note: 95% CI = 95% confidence interval.

Living arrangements

The living arrangements of ADF members and FWS participants are summarised in Table 3.2. The most common living arrangements for ADF members were for them to be living with a spouse/partner and child(ren) (66.7%) or as a couple on their own (21.0%). Comparison of Current Serving and Ex-Serving ADF members revealed significant differences, with Current Serving members being more likely to be living with a spouse/partner and child(ren) and less likely to be living just with a spouse/partner. Approximately two in three ADF members were living in the same households as FWS participants (68.3%), while just under one in four were living 100 or more kilometres away (23.7%). Current Serving ADF members were more likely to be living a long distance away than Ex-Serving ADF members; for example, 27.0% of Current Serving were living 100 or more kilometres away compared to 16.9% of Ex-Serving.

Table 3.2 Living arrangements of ADF members and FWS participants, stratified by ADF members' military status

Measure	Military status of ADF member							p-value
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			
	%	n	%	(95% CI)	n	%	(95% CI)	
ADF member's living arrangements								< 0.0001
Person living alone	3.7	25	3.4	(2.3 – 5.0)	17	4.3	(2.7 – 6.8)	
Couple living alone	21.0	120	16.4	(13.9 – 19.3)	117	29.5	(25.2 – 34.2)	
Couple with child(ren)	66.7	525	71.7	(68.3 – 74.9)	228	57.4	(52.5 – 62.2)	
Married with dependants unaccompanied*	3.0	26	3.6	(2.4 – 5.2)	8	2.0	(1.0 – 4.0)	
Single parent with child(ren)	1.5	12	1.6	(0.9 – 2.9)	5	1.3	(0.5 – 3.0)	
Other household type	4.1	24	3.3	(2.2 – 4.8)	22	5.5	(3.7 – 8.3)	
Missing		197			61			
Distance of ADF member's home from FWS participant								< 0.0001
In same household	68.3	616	66.8	(63.7 – 69.8)	325	71.3	(66.9 – 75.3)	
< 25 kilometres away	5.1	35	3.8	(2.7 – 5.2)	36	7.9	(5.7 – 10.8)	
25–100 kilometres away	2.9	22	2.4	(1.6 – 3.6)	18	3.9	(2.5 – 6.2)	
100–500 kilometres away	5.3	57	6.2	(4.8 – 7.9)	16	3.5	(2.2 – 5.7)	
500+ kilometres away	18.4	192	20.8	(18.3 – 23.6)	61	13.4	(10.5 – 16.8)	
Living arrangements of FWS participants								
Number of people living in FWS participants' households								0.20
1	5.7	53	5.7	(4.4 – 7.4)	26	5.7	(3.9 – 8.2)	
2	35.0	306	32.9	(30.0 – 36.0)	180	39.3	(34.9 – 43.9)	
3	19.0	181	19.5	(17.1 – 22.2)	83	18.1	(14.8 – 21.9)	
4	26.5	254	27.3	(24.6 – 30.3)	114	24.9	(21.1 – 29.1)	
5+	13.7	135	14.5	(12.4 – 17.0)	55	12.0	(9.3 – 15.3)	
Length of time FWS participants have lived in their current households								< 0.0001
≤ 1 year	18.0	181	19.5	(17.1 – 22.2)	69	15.1	(12.1 – 18.7)	
2 years	16.9	182	19.6	(17.2 – 22.3)	52	11.4	(8.7 – 14.6)	
3 years	11.7	111	11.9	(10.0 – 14.2)	51	11.1	(8.6 – 14.4)	
4 years	10.7	92	9.9	(8.1 – 12.0)	57	12.4	(9.7 – 15.8)	
5–9 years	20.7	170	18.3	(15.9 – 20.9)	117	25.5	(21.7 – 29.8)	
10–19 years	12.3	101	10.9	(9.0 – 13.0)	69	15.1	(12.1 – 18.7)	
20+ years	9.7	92	9.9	(8.1 – 12.0)	43	9.4	(7.0 – 12.4)	

* 'Married with dependants unaccompanied' means the ADF member is married and has children but the ADF member is living in another location while his/her spouse and dependent children are living in their previous location.

Note: 95% CI = 95% confidence interval.

Among FWS participants, only 5.7% were living on their own, 35.0% were living in a household with 2 people (35%), 19.0% with 3 people, 26.5% with 4 people and 13.7% with 5 or more people. Household size did not significantly differ across FWS participants whose ADF members were Current Serving or Ex-Serving. However, the length of time FWS participants had lived in their current household did show significant differences, with family members of Current Serving ADF members tending to have lived in their present household for less time than those whose ADF members were Ex-Serving. For instance, 50.0% of those with Ex-Serving ADF members had been residing in their present household for 5+ years compared with 39.1% of those with Current Serving ADF members.

Employment

A total of 33.1% FWS participants were not working at the time of the FWS, 39.7% were working full-time and 27.2% were part-time (Table 3.3). Of those who were working (n = 608), 17.4% had been in their current employment for under a year, 28.8% had been there for 2 to 4 years, 17.8% for 5 to 9 years, and 26.0% for 10 or more years. Around four in five had taken one or more periods of leave for six months or longer while at their current employment. There were no significant differences in the employment characteristics of those with current and Ex-Serving ADF members.

Table 3.3 FWS participants' employment characteristics, stratified by ADF members' military status

Measure	Military status of ADF member							p-value
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Current employment status								0.27
Working full-time	39.7	355	38.3	(35.3 – 41.5)	194	42.5	(38.0 – 47.1)	
Working part-time	27.2	253	27.3	(24.5 – 30.3)	123	26.9	(23.0 – 31.2)	
Not working	33.1	318	34.3	(31.3 – 37.5)	140	30.6	(26.6 – 35.0)	
Length of time in current employment*								0.38
≤ 1 year	17.4	109	17.9	(15.1 – 21.2)	52	16.4	(12.7 – 20.9)	
2–4 years	28.8	181	29.8	(26.3 – 33.5)	85	26.8	(22.2 – 32.0)	
5–9 years	27.8	166	27.3	(23.9 – 31.0)	91	28.7	(24.0 – 34.0)	
10–14 years	11.8	68	11.2	(8.9 – 14.0)	41	12.9	(9.7 – 17.1)	
15–19 years	5.9	30	4.9	(3.5 – 7.0)	25	7.9	(5.4 – 11.4)	
20+ years	8.3	54	8.9	(6.9 – 11.4)	23	7.3	(4.9 – 10.7)	
Periods of leave of 6 months or longer in current job*								0.32
Yes	82.2	494	81.3	(77.9 – 84.2)	266	83.9	(79.4 – 87.6)	

* Only asked of family members who are working full-time or part-time (All n = 925; Current n = 608; Ex-serving n = 317).
Note: 95% CI = 95% confidence interval.

3.1.3 Service history

More than four in five ADF members (83.2%) had experienced one or more military deployments, with this not significantly differing across Current Serving and Ex-Serving subgroups. FWS participants whose ADF members had been deployed were asked whether deployment experiences had been shared with them. Only 3.9% of ADF members had ‘never’ talked about their deployment(s), while 42.3% had talked ‘a little’, 31.9% ‘somewhat’ and 21.8% ‘a lot’. Ex-serving ADF members tended to have talked less often about their deployment experiences than those who were Current Serving.

Slightly fewer than one in five of FWS participants had served in the ADF (17.0%). Of these FWS participants, 45.4% had experienced one or more deployments, with no significant differences between those with Current Serving or Ex-Serving ADF members (Table 3.4).

Table 3.4 Military service history of ADF members and FWS participants, stratified by ADF members’ military status

Measure	Military status of ADF member							p-value
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			
	%	n	%	(95% CI)	n	%	(95% CI)	
ADF member was ever deployed								0.38
Yes	83.2	762	83.8	(81.3 – 86.1)	367	81.9	(78.1 – 85.2)	
Missing		20			10			
ADF members shared their deployment experience*								0.008
No	3.9	25	3.3	(2.2 – 4.8)	19	5.2	(3.3 – 8.0)	
A little	42.3	301	39.6	(36.1 – 43.1)	176	48.1	(43.0 – 53.2)	
Somewhat	31.9	256	33.6	(30.4 – 37.1)	104	28.4	(24.0 – 33.3)	
A lot	21.8	179	23.5	(20.6 – 26.7)	67	18.3	(14.7 – 22.6)	
FWS participant is a current or ex-ADF member								0.89
Yes	17.0	159	17.1	(14.8 – 19.7)	77	16.8	(13.6 – 20.5)	
FWS participant was ever deployed†								0.39
Yes	45.4	73	47.4	(39.6 – 55.4)	31	41.3	(30.6 – 53.0)	
Missing		20			10			
Parent was in ADF	29.4	243	26.3	(23.5 – 29.2)	163	35.8	(31.5 – 40.4)	0.0003

* Only asked of FWS participants whose ADF member was deployed (All n = 1,129; Current n = 762; Ex-serving n = 367).

† Only asked of current or ex-ADF FWS participants (All n = 236; Current n = 159; Ex-serving n = 77).

Note: 95% CI = 95% confidence interval.

Approximately three in ten FWS participants reported that one or both of their parents had served in the ADF (29.4%), with this significantly more common among those whose ADF members were Ex-Serving compared with Current Serving. This is unsurprising as it likely reflects the fact that the Ex-Serving subgroup contained a

higher percentage of adult children than the Current Serving subgroup (10.5% compared with 5.6%; $p < 0.001$; all adult children by definition had a parent who had served in the ADF).

3.1.4 The impact of service on ADF members and FWS participants

An important aspect examined by the FWS was the impact of military service on ADF members and on FWS participants. The following three issues were investigated:

- the effect of ADF members' military service on themselves as reported by FWS participants ($n = 1,387$)
- for those FWS participants who had served in the ADF, the effect of their own military service on themselves (reported by FWS participants; $n = 236$)
- the effect of ADF members' military service on family members as reported by civilian FWS participants ($n = 1,151$).

The areas examined were:

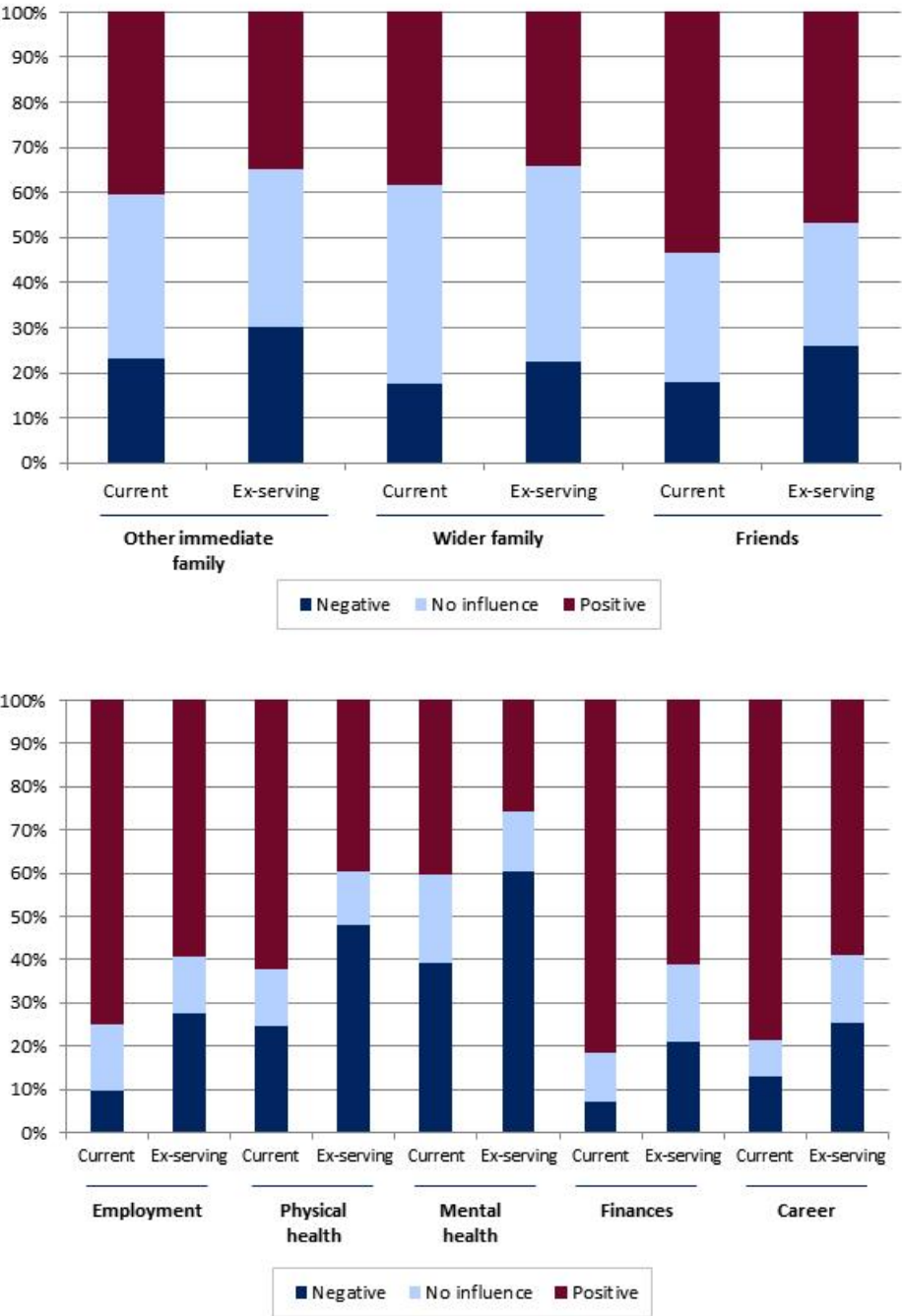
- relationships with other immediate family (excluding partners and children; this is reported later in Chapter 3)
- employment, careers and finances
- physical and mental health.

Effect of ADF members' military service on themselves

FWS participants' perceptions of the effect of ADF members' military service on ADF members themselves are presented in Figure 3.1 (for details, see Appendix C), stratified by ADF members' military status.

Overall, around seven in ten FWS participants thought military service had a positive effect on ADF members' financial situation (75.0%), careers (72.3%) and employment (69.8%). Around half thought it had a positive effect on ADF members' physical health (54.7%) and relationship with friends (51.2%). Slightly more than one in three thought there had been positive effects on mental health (35.6%) and ADF members' relationships with other immediate family (38.6%) and wider family (36.9%). However, some FWS participants thought there had been negative effects on ADF members, most notably in the areas of mental health (46.2%) and physical health (32.5%).

Figure 3.1 Perceived effect of ADF members’ military service on themselves, stratified by their military status as reported by family members



Comparisons of Ex-Serving and Current Serving groups revealed significant differences on all but one aspect (their relationships with their wider family), with FWS participants rating the effects of military service less positively for Ex-Serving than Current Serving ADF members. The largest differences were seen for employment (59.3% rated this positively compared with 75.2% of Current Serving), physical health (39.8% compared with 62.2%), mental health (25.8% compared with 40.5%), financial situation (61.1% compared with 81.7%), and careers (59.0% compared with 78.7%).

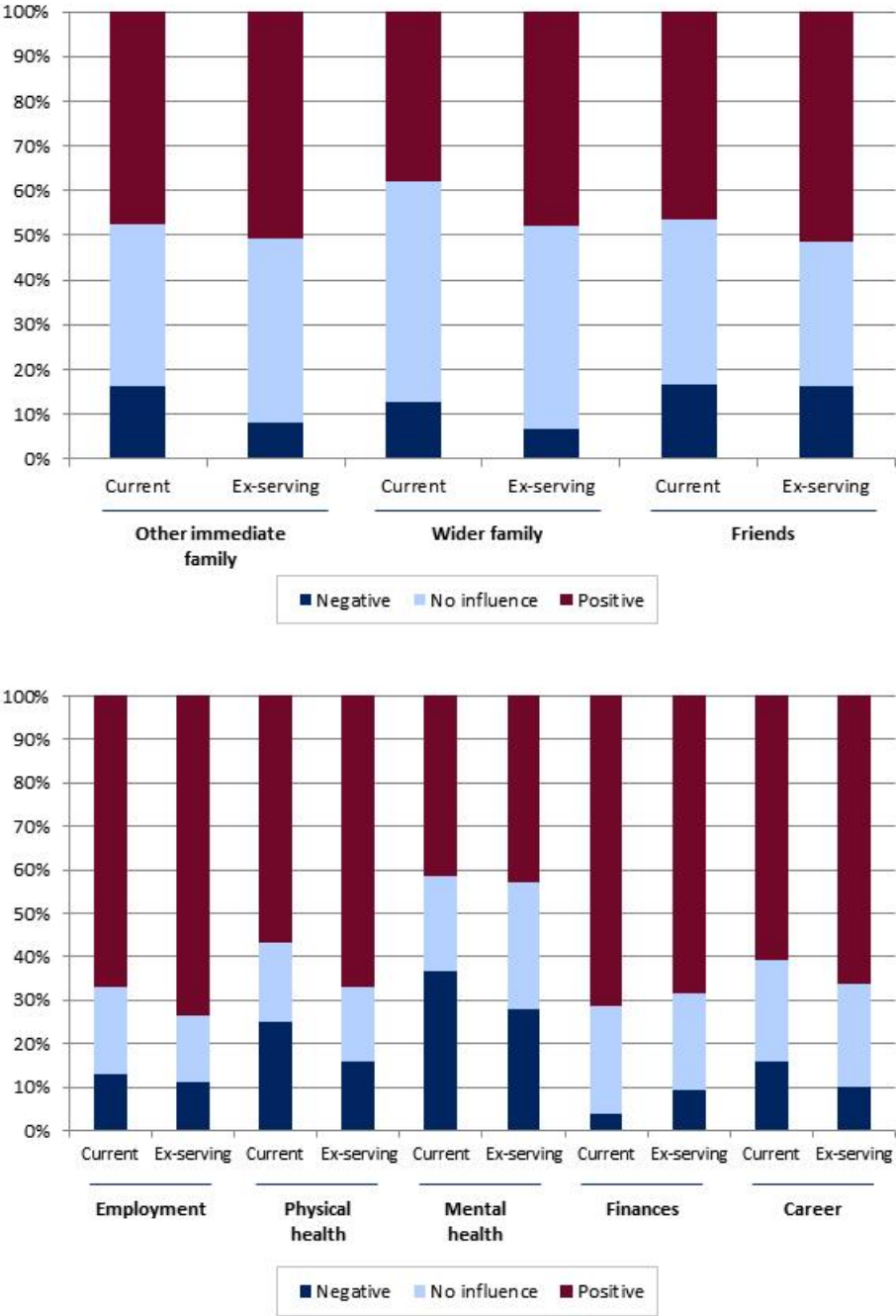
Effect of FWS participants' military service on themselves

FWS participants who were Current Serving or Ex-Serving ADF members answered questions on the effects of their own military service on themselves. Results are shown in Figure 3.2 (details in Appendix C), stratified by ADF members' military status. Overall, the majority rated the influence of their military service as having a positive effect on their own financial situation (70.2%), employment (69.2%), careers (62.7%) and physical health (60.4%). They also tended to be positive about the other areas examined: relationships with other immediate family (48.6%), friends (48.0%), wider family (41.5%) and mental health (41.9%). The areas in which the most frequent negative effects were reported were mental health (33.8%) and physical health (22.0%). There were no significant differences according to whether their ADF members were Current Serving or Ex-Serving.

Effect of ADF members' military service on civilian FWS participants

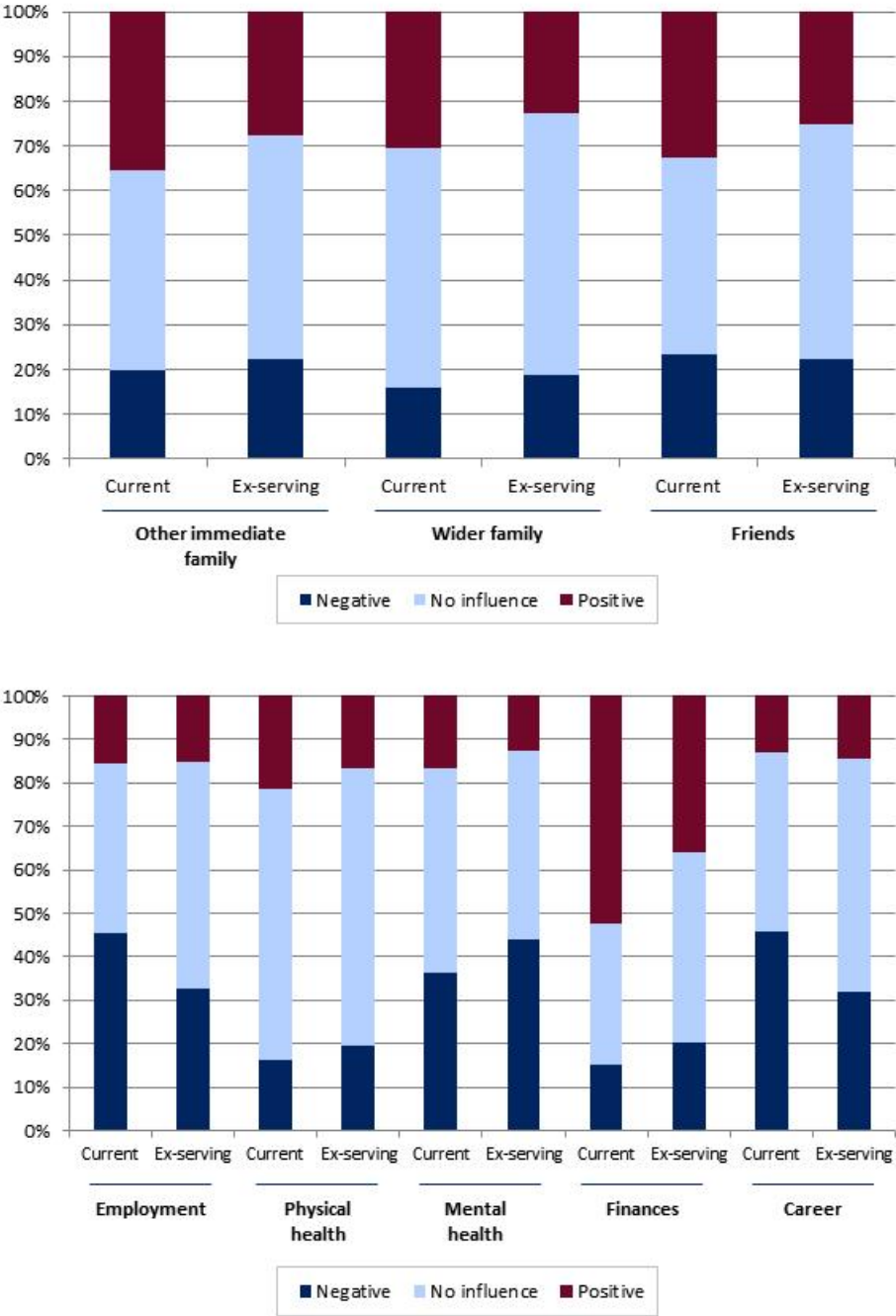
The perceived effects of ADF members' military service on civilian FWS participants are shown in Figure 3.3 (see Appendix C for details). The aspect on which ADF members' service was most frequently rated as being positive was FWS participants' financial situation (46.8%). Fewer FWS participants thought it had a positive effect on their own relationships with other immediate family (32.8%), friends (30.2%) and wider family (27.9%); their physical health (19.9%) and mental health (15.2%); and their employment (15.3%) and careers (13.5%). The areas in which negative effects were most often perceived to have occurred were the FWS participants' careers (41.2%), employment (41.0%) and mental health (38.8%). However, family members were most likely to report that their ADF members' service had no effect on these aspects of their lives (40–60%).

Figure 3.2 Perceived effect of FWS participants’ own current or former military service on themselves, stratified by military status of ADF members



Numerous significant differences were found between FWS participants whose ADF members were Ex-Serving or Current Serving, but the direction of differences varied across the aspects examined. Family members whose ADF members were Current Serving tended to be more positive about the effects of military service on their finances (52.3% rated this positively compared with 36.0% of Ex-Serving), relationships with immediate families (35.3% compared with 27.7%), wider families (30.6% compared with 22.6%) and friends (32.6% compared with 25.2%). On the other hand, family members whose ADF members were Current Serving tended to be more negative about the influence of military service on their employment (45.3% rated this negatively compared with 32.7% of Ex-Serving) and careers (45.8% compared with 32.0%). Finally, a significantly higher percentage of those with Ex-Serving ADF members perceived there had been negative effects on FWS participants' own mental health (43.9%) compared with their counterparts with Current Serving ADF members (36.3%).

Figure 3.3 Perceived effect of ADF members’ military service on civilian FWS participants, stratified by military status of ADF members



3.1.5 Summary

A brief summary of the findings reported in Section 3.1 is presented below. We summarise:

- the overall characteristics and perceptions of all FWS participants
- the family member characteristics that were found to significantly differ according to the Current Serving and Ex-Serving status of their ADF members
- the ADF member characteristics that were found to significantly differ across those who were Current Serving or Ex-Serving.

Overall

Demographic characteristics of FWS participants

- Few family members were aged 18 to 27 years (7.6%), with the family members fairly evenly distributed across the other age ranges: 22.0% were aged between 22 and 37 years, 26.4% between 38 and 47 years, 25.4% between 48 and 57 years, and 18.5% over 58 years.
- 85.3% were female.
- Around three-quarters had attained a post-secondary qualification, either a university degree (42.7%) or a diploma/certificate (34.2%).
- 1% self-identified as Indigenous.
- 69.4% were the spouses/partners of their ADF members; 19.8% were their parents; and 7.3% were their adult children (aged 18 years or more).

Living arrangements

- 66.7% of the ADF members of FWS participants were living with a spouse/partner and child(ren); and 21.0% were living with a spouse/partner only.
- 68.3% of ADF members were living in the same household as FWS participants.

Employment

- 66.9% of FWS participants were working.
- 39.7% of FWS participants were working full-time and 27.2% were part-time.

Service history

- 17.0% of FWS participants had served in the ADF.
- 45.4% of FWS participants who had served in the ADF had been deployed.

- 29.4% of FWS participants had a parent who had been an ADF member.
- 83.2% of ADF members of FWS participants had been deployed.
- Almost all ADF members had shared their deployment experiences with FWS participants (96.1%), most commonly 'a little' (42.3%) or 'somewhat' (31.9%).

Impact of military service

- FWS participants felt there had been positive effects of military service on ADF members' financial situation (75.0%), careers (72.3%) and employment (69.8%).
- Fewer family members rated military service as having a positive impact on ADF members' relationships with immediate (38.6%) and wider family members (36.9%), and mental health (35.6%).
- For FWS participants with a military service background, the effects of their own service were most often seen as positive on their financial situation (70.2%), employment (69.2%), careers (62.7%) and physical health (60.4%).
- For civilian FWS participants, around 40–60% felt military service has not affected them, while the percentage feeling there had been positive effects was especially low on their own employment (15.3%, with 41.0% reporting negative effects), careers (13.5%, with 41.2% reporting negative effects) and mental health (15.2%, with 38.8% reporting negative effects).

Family member characteristics that differed by the military status of ADF members

The demographic and background characteristics of FWS participants were compared by the military status of their ADF members. Statistically significant differences found were on:

- **age** – FWS participants with Ex-Serving ADF members tended to be older
- **residential stability** – FWS participants with Ex-Serving ADF members had been resident in their current home for a longer period of time
- **across-generations military service** – a higher percentage of those with an Ex-Serving ADF member had a parent who had served in the ADF (this likely reflects the higher percentage of adult children in the Ex-Serving subgroup)
- **effect of ADF members' military service on civilian FWS participants** – significantly more FWS participants of Current Serving than Ex-Serving ADF members felt there had been positive effects on their own relationships with immediate and wider family members, friends, and financial situation. Those whose ADF members were Ex-Serving also more often perceived there had been

negative effects on their mental health. Finally, those whose ADF members were Current Serving more often perceived there had been negative effects on their own employment and career development.

No statistical evidence was found that family members of Current Serving and Ex-Serving ADF members differed on their sex, educational background, self-identified Indigenous status, household size, employment characteristics, and their military service history. For FWS participants who have themselves served in the ADF, no statistical evidence of differences was found on the impact of their own service on their relationships, employment, financial situation, career, mental and physical health.

ADF member characteristics that differed by their military status

The focus of the FWS was on the wellbeing of family members of Current Serving and Ex-Serving ADF members. Thus, there were fewer questions about the lives and wellbeing of the individuals who participated in the Mental Health and Wellbeing Transition Study who nominated family members for contact regarding participation in the FWS.

Nevertheless, the following differences between Current Serving and Ex-Serving ADF members were found:

- **household type** – Current Serving ADF members were more likely to be living in a household with a spouse/partner and child(ren), while Ex-Serving ADF members were more likely to be in a household with just a spouse/partner
- **distance from FWS participants** – Current Serving ADF members were more likely to be living further away
- **military service experiences** – fewer Ex-Serving ADF members had talked with FWS participants about their deployment experiences
- **effect of military service on ADF members** – according to family members, Ex-Serving ADF members had experienced fewer positive effects from military service than Current Serving ADF members, especially on employment, financial situation, and careers. Additionally, they were perceived to have experienced more mental and physical health negative effects than Current Serving ADF members.

3.2 How were military spouses/partners faring?

This section reports on the wellbeing of spouses/partners and ex-spouses/ex-partners of Current Serving and Ex-Serving ADF members. The data were combined across current and ex-spouses/partners and they are referred to as 'spouses/partners' from here on (unless otherwise specified). The responses of all current and former spouses/partners are first described, then compared by the military status of their ADF members. Six broad areas are examined:

1. demographic and background characteristics (e.g. age, sex, education, living arrangements, employment, financial hardships)
2. residential and school mobility (e.g. how many moves made during ADF members' military service, how many moves made as a direct result of ADF members' military service, reasons for latest move)
3. the military service history of ADF members and spouses/partners and its impact (e.g. whether they have served in the ADF, whether they have been deployed, perceptions of the impact of military service)
4. within-family relationships (e.g. marital relationship quality, relationships with children, parenting practices, children's adjustment)
5. spouses'/partners' health (e.g. physical health, experience of trauma, risky behaviours, mental health, help seeking, assistance for mental health problems, barriers)
6. ADF members' mental health (e.g. assistance for mental health problems, diagnosed mental health conditions).

3.2.1 Method

Sample

This section uses the spouse/partner data from 'Sample 3: Spouse/partner data' and 'Sample 4: Linked spouse/partner data' (see Chapter 2 for more details). The sample comprises 983 spouses/partners who had complete demographic data and had completed at least half of the survey (Sample 3). Over two in three were the spouses/partners of Current Serving ADF members (n = 596; 69%) and three in 10 Ex-Serving ADF members (n = 272; 31%). Of these, 868 (88%) had ADF members who agreed to have their survey responses linked to their partners'/spouses' data (Sample 4).

Statistical analysis

Summary statistics are provided for all spouses/partners and stratified by the serving status of ADF members (Current Serving or Ex-Serving). For categorical measures, percentages have been calculated, with the difference between spouses/partners of Current Serving and Ex-Serving ADF members tested using the chi-square test or Fisher's exact test. The latter test was used if an expected cell count was fewer than five people. For continuous measures, the mean and standard deviation were calculated and differences tested using *t*-tests. All tests were two-sided and *p*-values are included in the tables so that the strength of the evidence of a statistically significant difference between the two groups can be assessed. We have interpreted *p*-values of ≤ 0.05 as providing sufficient evidence of a difference.

3.2.2 Demographic characteristics

This section reports on the personal characteristics of spouses/partners, such as their age, sex, highest level of education, and whether they had a child with their ADF member. Few spouses/partners were aged 18 to 27 years (3.8%), 28.0% were 28 to 37 years, 35.1% were 38 to 47 years, 27.4% were 48 to 57 years, and 5.7% were 58 years or older (Table 3.5).

Spouses/partners of Ex-Serving ADF members tended to be significantly older than the spouses/partners of Current Serving ADF members. For example, 14.0% of those with Ex-Serving ADF members were aged 58 years or older compared to 1.8% of those with Current Serving ADF members. Almost all spouses/partners were female (91.7%). Approximately one in five reported their highest level of education to be primary or secondary school (19.1%), while around one in three had attained a post-secondary certificate or diploma (33.9%) and just under half had attained a university degree (47.0%). Almost all were the current spouses or partners of their ADF members (97.7%) and 81.2% had a child with their ADF member. There was no statistical evidence that the spouses/partners of Current Serving and Ex-Serving ADF members differed in terms of their sex, highest level of education, relationship to ADF member or having a child with their ADF member.

3.2.3 Living arrangements

A total of 70.6% of ADF members were living in a household with a spouse/partner and child(ren), 21.9% were living only with a spouse/partner, and 7.5% had other types of household arrangements (Table 3.6). Ex-Serving ADF members were significantly more likely to be living only with a spouse/partner (31.3% compared with 17.4% of Current Serving ADF members) and less likely to be living with a spouse/partner and child(ren) (62.3% compared with 74.5%). Almost nine out of ten spouses/partners were living in the same household as their ADF members (89.7%), with spouses/partners of Current Serving ADF members significantly less likely to be living in the same household (87.2%) than spouses/partners of Ex-Serving ADF members (95.2%).

When describing their own household, 2.1% of spouses/partners said they lived alone, 28.9% with one other person, 20.9% as a household with three people, 31.9% with four people and 16.2% with five or more people. Spouses/partners of Current Serving ADF members were significantly less likely to be living in a two-person household (25.0% compared with 37.5% of those with Ex-Serving ADF members). Spouses/partners of Ex-Serving ADF members tended to have lived in their current residence for significantly longer, with 44.8% having been there for five or more years compared with 27.7% of those with Current Serving ADF members.

Table 3.5 Personal characteristics of spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Age (years)								0.001
18 – < 28	3.8	26	4.4	(3.0 – 6.3)	7	2.6	(1.2 – 5.3)	
28 – < 38	28.0	171	28.7	(25.2 – 32.5)	72	26.5	(21.5 – 32.1)	
38 – < 48	35.1	228	38.3	(34.4 – 42.2)	77	28.3	(23.2 – 34.0)	
48 – < 58	27.4	160	26.8	(23.4 – 30.6)	78	28.7	(23.6 – 34.4)	
58+	5.7	11	1.8	(1.0 – 3.3)	38	14.0	(10.3 – 18.7)	
Sex								0.34
Female	91.7	543	91.1	(88.5 – 93.1)	253	93.0	(89.3 – 95.5)	
Male	8.3	53	8.9	(6.9 – 11.5)	19	7.0	(4.5 – 10.7)	
Highest level of education								0.21
Primary/secondary school	19.1	105	17.6	(14.8 – 20.9)	61	22.4	(17.8 – 27.8)	
Certificate/diploma	33.9	209	35.1	(31.3 – 39.0)	85	31.3	(26.0 – 37.0)	
University degree	47.0	282	47.3	(43.3 – 51.3)	126	46.3	(40.4 – 52.3)	
Relationship to ADF member								0.90
Spouse/partner	97.7	582	97.7	(96.1 – 98.6)	266	97.8	(95.2 – 99.0)	
Ex-spouse	2.3	14	2.3	(1.4 – 3.9)	6	2.2	(1.0 – 4.8)	
Child with ADF member								0.20
No	18.8	104	17.7	(14.8 – 21.0)	58	21.3	(16.8 – 26.6)	
Yes	81.2	485	82.3	(79.0 – 85.2)	214	78.7	(73.4 – 83.2)	

Note: 95% CI = 95% confidence interval.

Table 3.6 Living arrangements of ADF members and spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
ADF MEMBERS' LIVING ARRANGEMENTS*								0.0003
ADF member's household type		12	2.2	(1.2 – 3.8)	< 5	1.5	(0.6 – 4.0)	
Person living alone	2.0	97	17.4	(14.5 – 20.8)	83	31.3	(26.0 – 37.2)	
Couple living alone	21.9	415	74.5	(70.7 – 78.0)	165	62.3	(56.2 – 67.9)	
Couple with child(ren)	70.6	20	3.6	(2.3 – 5.5)	5	1.9	(0.8 – 4.5)	
Married with dependants unaccompanied†	3.0	< 5	0.4	(0.1 – 1.4)	< 5	0.0		
Single parent with child(ren)	0.2	11	2.0	(1.1 – 3.5)	8	3.0	(1.5 – 5.9)	
Other household type	2.3	39			7			
Missing								0.002
Distance of ADF member's home from family member		519	87.2	(84.3 – 89.7)	259	95.2	(91.9 – 97.2)	
In same household	89.7	5	0.8	(0.3 – 2.0)	< 5	1.1	(0.4 – 3.4)	
Less than 25 kilometres away	0.9	10	1.7	(0.9 – 3.1)	< 5	1.1	(0.4 – 3.4)	
Between 25 and 100 kilometres away	1.5	22	3.7	(2.4 – 5.6)	< 5	0.4	(0.1 – 2.6)	
Between 100 and 500 kilometres away	2.7	39	6.6	(4.8 – 8.9)	6	2.2	(1.0 – 4.8)	
More than 500 kilometres away	5.2							
SPOUSES/PARTNERS' LIVING ARRANGEMENTS*								0.003
Number of people living in FWS participant's household		15	2.5	(1.5 – 4.1)	< 5	1.1	(0.4 – 3.4)	
1	2.1	149	25.0	(21.7 – 28.6)	102	37.5	(31.9 – 43.4)	
2	28.9	131	22.0	(18.8 – 25.5)	50	18.4	(14.2 – 23.5)	
3	20.9	196	32.9	(29.2 – 36.8)	81	29.8	(24.6 – 35.5)	
4	31.9	105	17.6	(14.8 – 20.9)	36	13.2	(9.7 – 17.8)	
5+	16.2							< 0.0001
Length of time FWS participant has lived in current household		127	21.3	(18.2 – 24.8)	40	14.7	(11.0 – 19.5)	
≤ 1 year	19.2	146	24.5	(21.2 – 28.1)	40	14.7	(11.0 – 19.5)	
2 years	21.4	85	14.3	(11.7 – 17.3)	36	13.2	(9.7 – 17.8)	
3 years	13.9	73	12.2	(9.8 – 15.1)	34	12.5	(9.1 – 17.0)	
4 years	12.3	104	17.4	(14.6 – 20.7)	75	27.6	(22.6 – 33.2)	
5–9 years	20.6	54	9.1	(7.0 – 11.7)	36	13.2	(9.7 – 17.8)	
10–19 years	10.4	7	1.2	(0.6 – 2.4)	11	4.0	(2.2 – 7.2)	
20+ years	2.1							

* Reported by spouses/partners.

† 'Married with dependants unaccompanied' means the ADF member is married and has children but the ADF member is living in another location while his/her spouse and dependent children are living in their previous location.

Note: 95% CI = 95% confidence interval.

3.2.4 Economic wellbeing

Being without a permanent place to live

Spouses/partners were asked a series of questions about whether they had ever been without a permanent place to live and the reasons for this. Almost one in four reported that they had been without a permanent place to live at some stage (23.5%), with significantly more spouses/partners of Ex-Serving than Current Serving ADF members reporting they had been in this situation (28.3% compared with 21.3%; see Table 3.7).

Spouses/partners who had ever been without a permanent place to live (n = 204) were then asked how many times this had occurred, when the last episode had occurred and its length, and their reasons for being without a permanent place to live. Overall, 60.0% had experienced one episode of being without a permanent place to live, 21.0% two episodes, 10.3% three episodes and 8.7% four or more episodes. There was no significant difference between spouses/partners of Current Serving and Ex-Serving ADF members in the number of episodes experienced.

Of those who had not had a permanent place to live at some stage, 12.4% had last experienced this under a year ago, 12.4% 1 – < 2 years ago, 19.1% 2 – < 5 years ago, 24.2% 5 – < 5 years ago and 32.0% 5+ years ago. No statistical evidence was found that spouses/partners of Current Serving and Ex-Serving ADF members differed on the timespan since they had last been without a permanent place to live. Around one in three had been without a permanent place to live for less than a month during their last episode (32.4%), half for between one and up to six months (51.4%), and this had been more long-term for 16.2% (i.e. six months or more). Additionally, a significantly longer timespan had elapsed since spouses/partners of Ex-Serving ADF members had last been without a permanent place to live (22.5% had experienced this for six months or more compared to 12.3% of those with Current Serving ADF members).

The most common reason for being without a permanent place to live was to move to a town or city (39.7%). The next most common reasons were: family/friend relationship problems (25.0%), a work-related reason (19.1%), and travelling or being on holiday (16.7%). Few reported financial problems as reasons (e.g. not being able to pay the mortgage or rent – 7.3%; loss of job – 2.0%), while 6.4% reported this to be because of violence/abuse/neglect. (It should be noted that respondents could choose more than one reason; hence, these percentages do not sum to 100%.)

Spouses/partners of Current Serving and Ex-Serving ADF members significantly differed only on the percentage giving travelling or holidaying as a reason, with this being higher among those with Ex-Serving ADF members.

Table 3.7 Being without a permanent place to live among spouses/partners, stratified by military status of ADF member

Measure*	Military status of ADF member							p-value
	All (n = 204)	Current (n = 127)			Ex-serving (n = 77)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever without a permanent place to live	23.5	127	21.3	(18.2 – 24.8)	77	28.3	(23.2 – 34.0)	0.02
Number of times without a permanent place to live								0.28
1	60.0	76	62.3	(53.3 – 70.5)	41	56.2	(44.4 – 67.3)	
2	21.0	28	23.0	(16.3 – 31.4)	13	17.8	(10.5 – 28.6)	
3	10.3	10	8.2	(4.4 – 14.7)	10	13.7	(7.4 – 23.9)	
4+	8.7	8	6.6	(3.3 – 12.7)	9	12.3	(6.4 – 22.3)	
When last did not have a permanent place to live								0.72
< 1 year ago	12.4	14	11.9	(7.1 – 19.2)	10	13.2	(7.1 – 23.0)	
1 – < 2 years ago	12.4	15	12.7	(7.8 – 20.1)	9	11.8	(6.2 – 21.5)	
2 – < 5 years ago	19.1	21	17.8	(11.8 – 25.9)	16	21.1	(13.2 – 31.9)	
5 – < 10 years ago	24.2	26	22.0	(15.4 – 30.5)	21	27.6	(18.6 – 39.0)	
10+ years ago	32.0	42	35.6	(27.4 – 44.8)	20	26.3	(17.5 – 37.6)	
Last time, how long without a permanent place to live								0.04
< 1 month	32.4	44	38.6	(30.0 – 48.0)	16	22.5	(14.1 – 34.0)	
1 – < 6 months	51.4	56	49.1	(39.9 – 58.4)	39	54.9	(43.0 – 66.3)	
6+ months	16.2	14	12.3	(7.4 – 19.8)	16	22.5	(14.1 – 34.0)	
Reasons for being without a permanent place to live†								
Travelling/on holiday	16.7	16	12.6	(7.8 – 19.7)	18	23.4	(15.1 – 34.4)	0.05
Work-related reason	19.1	26	20.5	(14.3 – 28.5)	13	16.9	(9.9 – 27.2)	0.53
House-sitting	1.5	< 5	1.6	(0.4 – 6.2)	< 5	1.3	(0.2 – 9.0)	0.87
Saving money	7.3	9	7.1	(3.7 – 13.2)	6	7.8	(3.5 – 16.5)	0.85
Just moved back/into town or city	39.7	45	35.4	(27.5 – 44.2)	36	46.8	(35.7 – 58.1)	0.11
Building or renovating home	7.8	9	7.1	(3.7 – 13.2)	7	9.1	(4.3 – 18.1)	0.61
Tight housing/rental market	6.4	8	6.3	(3.2 – 12.2)	5	6.5	(2.7 – 14.9)	0.96
Violence/abuse/neglect	6.4	9	7.1	(3.7 – 13.2)	< 5	5.2	(1.9 – 13.3)	0.59
Family/friend/relationship problems	25.0	32	25.2	(18.3 – 33.6)	19	24.7	(16.2 – 35.8)	0.93
Financial problems (e.g. unable to pay mortgage or rent)	7.3	6	4.7	(2.1 – 10.2)	9	11.7	(6.1 – 21.2)	0.06
Lost job	2.0	< 5	1.6	(0.4 – 6.2)	< 5	2.6	(0.6 – 10.1)	0.61
Natural disaster	1.0	< 5	0.8	(0.1 – 5.5)	< 5	1.3	(0.2 – 9.0)	0.72
Other reason	15.7	23	18.1	(12.3 – 25.9)	9	11.7	(6.1 – 21.2)	0.22

* Only asked of spouses/partners who have ever been without a permanent place to live.

† Spouses/partners could select all that applied.

Note: 95% CI = 95% confidence interval.

Employment

The majority of spouses/partners were working at the time of the survey, with 41.6% being full-time, 27.2% part-time and 31.2% not in employment (Table 3.8). There were no significant differences between those with Current Serving and Ex-Serving ADF members on the percentages in employment. Those working were asked how long they had been at their current place of employment, with this being most commonly 2 to 4 (29.9%) or 5 to 9 years (29.6%). One or fewer years was the next most common length of time (18.0%). There were no significant differences between those with Current Serving and Ex-Serving ADF members on length of time in their current employment. Of those who were in employment at the time of the FWS, almost four in five had experienced a leave period of six months or longer while in their current job (79.3%) rather than being continuously employed, with this not significantly differing across spouses/partners of Current Serving or Ex-Serving ADF members.

Table 3.8 Spouses'/partners' employment, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Current employment status								0.35
Working full-time	41.6	238	40.1	(36.2 – 44.1)	122	45.0	(39.2 – 51.0)	
Working part-time	27.2	168	28.3	(24.8 – 32.1)	67	24.7	(19.9 – 30.2)	
Not working	31.2	188	31.6	(28.0 – 35.5)	82	30.3	(25.1 – 36.0)	
Length of time in current employment*								0.74
≤ 1 year	18.0	78	19.2	(15.7 – 23.4)	29	15.3	(10.8 – 21.3)	
2–4 years	29.9	125	30.8	(26.5 – 35.5)	53	28.0	(22.1 – 34.9)	
5–9 years	29.6	116	28.6	(24.4 – 33.2)	60	31.7	(25.5 – 38.8)	
10–14 years	11.4	45	11.1	(8.4 – 14.5)	23	12.2	(8.2 – 17.7)	
15–19 years	5.2	19	4.7	(3.0 – 7.2)	12	6.3	(3.6 – 10.9)	
20+ years	5.9	23	5.7	(3.8 – 8.4)	12	6.3	(3.6 – 10.9)	
Periods of leave of 6 months or longer in current job*								0.65
Yes	79.3	320	78.8	(74.6 – 82.5)	152	80.4	(74.1 – 85.5)	
No	20.7	86	21.2	(17.5 – 25.4)	37	19.6	(14.5 – 25.9)	

* Only asked of spouses/partners who are working full- or part-time (All n = 595; Current n = 406; Ex-serving n = 189).

Note: 95% CI = 95% confidence interval.

Sources of income and financial hardship

Very similar percentages of all spouses/partners reported their main source of income was paid employment (45.9%) or their ADF members' income (44.2%), with approximately nine in ten overall reporting these as their main income sources (Table 3.9). There were significant differences when comparing those with Current Serving or Ex-Serving ADF members, with reliance on spouse's/partner's income being significantly less typical of those with Ex-Serving (32.0%) than Current Serving ADF members (49.8%).

Table 3.9 Spouses'/partners' income sources and experience of financial hardships, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Main source of income								< 0.0001
Paid employment	45.9	260	43.6	(39.7 – 47.6)	138	50.7	(44.8 – 56.7)	
Self-employment	3.3	16	2.7	(1.6 – 4.3)	13	4.8	(2.8 – 8.1)	
Spouse's/partner's income	44.2	297	49.8	(45.8 – 53.9)	87	32.0	(26.7 – 37.8)	
Parent's financial support	0.2	< 5	0.2	(0.0 – 1.2)	< 5	0.4	(0.1 – 2.6)	
Government allowance	3.3	14	2.3	(1.4 – 3.9)	15	5.5	(3.3 – 9.0)	
Other	3.0	8	1.3	(0.7 – 2.7)	18	6.6	(4.2 – 10.3)	
Financial hardship*								
Could not pay electricity, gas or telephone bills on time	16.1	88	15.0	(12.4 – 18.2)	49	18.4	(14.1 – 23.5)	0.22
Could not pay the mortgage or rent on time	6.0	28	4.8	(3.3 – 6.9)	23	8.8	(5.9 – 12.9)	0.02
Pawned or sold something	9.5	46	8.0	(6.0 – 10.5)	34	12.9	(9.3 – 17.5)	0.02
Went without meals	4.2	21	3.6	(2.4 – 5.5)	14	5.3	(3.2 – 8.8)	0.25
Was unable to heat home	4.1	21	3.6	(2.4 – 5.5)	13	5.0	(2.9 – 8.5)	0.35
Asked for financial help from friends or family	15.1	73	12.5	(10.0 – 15.4)	55	20.9	(16.4 – 26.3)	0.002
Asked for help from welfare/ community organisations	5.7	27	4.7	(3.2 – 6.7)	21	8.0	(5.2 – 12.0)	0.05
Increased credit card debt or bank debts	24.3	140	24.1	(20.7 – 27.7)	66	25.0	(20.1 – 30.6)	0.77
Number of types of financial hardship								0.12
None	67.1	399	68.8	(68.8 – 72.4)	166	63.4	(57.3 – 69.0)	
1 type of hardship	12.7	75	12.9	(12.9 – 15.9)	32	12.2	(8.7 – 16.8)	
2+ types of hardship	20.2	106	18.2	(18.2 – 21.6)	64	24.4	(19.8 – 30.0)	

* Spouses/partners could select as many financial hardships as applied.
Note: 95% CI = 95% confidence interval.

Spouses/partners were also asked whether they had experienced various types of financial hardships in the previous two years because of a shortage of money (Table 3.9). Overall, two in three spouses/partners reported their families had not experienced any of the hardships assessed (67.1%), 12.7% had experienced one, and one in five families had experienced two or more (20.2%). There were no significant differences between families of Current Serving and Ex-Serving ADF members on whether they had experienced financial hardships.

Looking next at specific types of hardships experienced by families, the most frequently reported was increased credit card or bank debt (24.3%), with the next most frequent being not being able to pay electricity, gas or telephone bills on time (16.1%) and having to ask friends or family for financial help (15.1%). The other types of financial hardships were reported by fewer than 10.0%. Those with Ex-Serving ADF members significantly more often reported they had not been able to pay the mortgage or rent on time; needed to pawn or sell something; ask for financial help from friends or family; and had sought help from community organisations than their counterparts with Current Serving ADF members. For example, 8.8% were struggling to pay the mortgage or rent on time and 20.9% had sought financial help from friends or family compared with 4.8% and 12.5% respectively of those with Current Serving ADF members.

3.2.5 Residential and school mobility

Residential mobility

Family mobility is known to be a significant issue for many military families, as discussed in Chapter 1. Therefore, spouses/partners were asked about the number of places they had lived in during their ADF members' ADF period of service, and the number of moves that had been made as a direct result of their ADF members' military service. Those with Ex-Serving ADF members were also asked about the number of places they had lived in since their ADF members had left service.

Across all civilian spouses/partners, the most common number of places lived in during their ADF members' service was 3 to 4 (30.3%), followed by 5 to 6 (21.5%), two or less (19.2%) and 7 to 8 (12.3%). Significant differences were evident (Table 3.10), with spouses/partners of Ex-Serving ADF members more likely to have experienced two or fewer moves and less likely to have experienced 3 to 4 moves (the subgroups were very similar on the other categories).

Table 3.10 Residential mobility among civilian spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Number of places lived during ADF member's service								0.003
1–2	19.2	83	15.9	(13.0 – 19.3)	55	28.4	(22.4 – 35.2)	
3–4	30.3	175	33.5	(29.5 – 37.6)	42	21.6	(16.4 – 28.1)	
5–6	21.5	114	21.8	(18.5 – 25.6)	40	20.6	(15.5 – 27.0)	
7–8	12.3	65	12.4	(9.9 – 15.6)	23	11.9	(8.0 – 17.3)	
9–10	7.2	38	7.3	(5.3 – 9.8)	14	7.2	(4.3 – 11.9)	
11+	9.5	48	9.2	(7.0 – 12.0)	20	10.3	(6.7 – 15.5)	
Missing		73			78			
Number of moves due to ADF member's service								< 0.0001
0	15.3	53	10.5	(8.1 – 13.5)	62	25.2	(20.1 – 31.0)	
1–2	22.1	115	22.7	(19.3 – 26.6)	51	20.7	(16.1 – 26.3)	
3–4	23.0	132	26.1	(22.4 – 30.1)	41	16.7	(12.5 – 21.9)	
5–6	15.4	82	16.2	(13.2 – 19.7)	34	13.8	(10.0 – 18.8)	
7+	24.2	124	24.5	(20.9 – 28.5)	58	23.6	(18.7 – 29.3)	
Missing		90			26			
Number of places lived after ADF member left service*								
0–1					127	65.5	(58.4 – 71.9)	
2					48	24.7	(19.1 – 31.4)	
3+					19	9.8	(6.3 – 14.9)	
Missing					78			

* Only asked of spouses/partners if ADF member had left service.

Note: 95% CI = 95% confidence interval.

The next issue examined is the number of relocations made as a direct result of ADF members' military service. There was considerable diversity here and no clear-cut trend emerged. Thus, 15.3% had never moved, 22.1% had moved 1 to 2 times, 23.0% had moved 3 to 4 times, 15.4% had 5 to 6 moves and 24.2% had moved 7 or more times. Significantly more spouses/partners of Current Serving ADF members had moved as a result of military service. For example, 26.1% had moved between 3 and 4 times compared with 16.7% of those with Ex-Serving ADF members, while fewer (10.5%) had never moved compared with 25.2% of those with Ex-Serving ADF members. Among those with Ex-Serving ADF members, around two in three had lived in the same place or moved to a new place only once since their ADF member left service, while one in four had lived in two places and one in ten in three or more.

Similar questions were asked of spouses/partners who were themselves current or Ex-Serving ADF members (n = 152; see Table 3.11). The number of moves made because

of their own service was most commonly 7+ (25.6%), followed by 3 to 4 (21.8%), 5 to 6 (19.5%), 1 to 2 (17.3%), and no moves (15.8%). Those with Current Serving or Ex-Serving ADF members did not significantly differ on the number of places lived in, or the number of residential moves made because of their own service. Among the 45 spouses/partners who were Ex-Serving ADF members, their most frequent number of moves since leaving service was 4 to 5 (44.6%), followed by one move (23.0%), with this not significantly differing across those with Current Serving or Ex-Serving ADF members.

Table 3.11 Residential mobility among spouses/partners who had served in the ADF, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 152)	Current (n = 107)			Ex-serving (n = 45)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Number of places lived during their own service								0.64
1–2	20.4	21	19.6	(13.1 – 28.4)	10	22.2	(12.1 – 37.2)	
3–4	24.3	28	26.2	(18.6 – 35.5)	9	20.0	(10.5 – 34.8)	
5–6	16.5	16	15.0	(9.3 – 23.2)	9	20.0	(10.5 – 34.8)	
7–8	12.5	12	11.2	(6.4 – 18.9)	7	15.6	(7.4 – 29.9)	
9–10	6.6	6	5.6	(2.5 – 12.1)	< 5	8.9	(3.2 – 22.1)	
11+	19.7	24	22.4	(15.4 – 31.5)	6	13.3	(5.9 – 27.3)	
Number of moves due to their own service								0.54
0	15.8	14	15.4	(9.2 – 24.5)	7	16.7	(7.9 – 31.8)	
1–2	17.3	14	15.4	(9.2 – 24.5)	9	21.4	(11.2 – 37.0)	
3–4	21.8	20	22.0	(14.5 – 31.8)	9	21.4	(11.2 – 37.0)	
5–6	19.5	16	17.6	(11.0 – 27.0)	10	23.8	(13.0 – 39.6)	
7+	25.6	27	29.7	(21.1 – 40.0)	7	16.7	(7.9 – 31.8)	
Missing		16			3			
Number of places lived after leaving service*								0.32
1	23.0	8	17.8	(8.9 – 32.4)	9	31.0	(16.3 – 51.0)	
2	13.5	7	15.6	(7.4 – 29.9)	< 5	10.3	(3.1 – 29.1)	
3	18.9	7	15.6	(7.4 – 29.9)	7	24.1	(11.4 – 44.0)	
4+	44.6	23	51.1	(36.3 – 65.8)	10	34.5	(18.9 – 54.3)	

* Only asked of spouses/partners if they had left service (All n = 74; Current n = 45; Ex-serving n = 29).

Note: 95% CI = 95% confidence interval.

Finally, all spouses/partners were asked the reasons for their most recent move (they could choose more than one, hence the percentages do not add to 100%). The most frequent reason chosen was a military posting or deployment (54.2%), with the next most frequent being to live in a place of their own (15.7%). As would be expected, those with Current Serving ADF members were significantly more likely to give a military posting or deployment as a reason compared with those whose ADF members were Ex-Serving (Table 3.12). On the other hand, those with Ex-Serving ADF members significantly more often gave work, to get a place of their own, and for family and friends as reasons than did those with Current Serving ADF members.

Table 3.12 Reasons for the most recent move, stratified by military status of ADF member

Measure*	Military status of ADF member							
	All (n = 696)	Current (n = 507)			Ex-serving (n = 189)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Military posting/deployment	54.2	338	66.7	(62.4 – 70.6)	39	20.6	(15.4 – 27.1)	< 0.0001
Transition from ADF	9.9	5	1.0	(0.4 – 2.4)	64	33.9	(27.4 – 41.0)	< 0.0001
For work†	8.5	31	6.1	(4.3 – 8.6)	28	14.8	(10.4 – 20.7)	0.0002
Better place/neighbourhood‡	8.6	43	8.5	(6.3 – 11.3)	17	9.0	(5.6 – 14.0)	0.83
To get a place of my own	15.7	71	14.0	(11.2 – 17.3)	38	20.1	(14.9 – 26.5)	0.05
For family/friends#	12.8	54	10.7	(8.2 – 13.7)	35	18.5	(13.6 – 24.8)	0.006
Other reason	14.5	67	13.2	(10.5 – 16.5)	34	18.0	(13.1 – 24.2)	0.11

* Spouses/partners could select all that applied.

† Categories with low frequencies were combined, e.g. to start a new job, to be nearer to place of work, work transfer, to start own business, relocation of own business, to look for work.

‡ Due to low frequencies, the categories to get a larger/better place, and to live in a better neighbourhood, were combined.

Due to low frequencies, to get married / move in with partner, to be closer to friends/family, to follow a spouse/partner who moved, for a child's schooling, were combined.

Notes: Questions in this table were only asked of spouses/partners who reported that they had lived at > 1 place during ADF members' service, or > 1 place after ADF member had left service, or > 1 place during their own ADF service, or > 1 place after their own service.
95% CI = 95% confidence interval.

School mobility

Disruption of children's schooling is another important issue for military families. Thus, spouses/partners who had school-age children with their ADF members (n = 414) were asked about the number of schools their children had attended during ADF members' military service, as well as the number of schools attended since ADF members had left service. Over all spouses/partners with children, the most common number of schools attended during ADF members' service was two (25.1%), with another 57.5% attending three or more schools during this period. Children with Current Serving and Ex-Serving ADF members did not significantly differ on the number of schools attended by children during their ADF members' service (Table 3.13). There appeared to be more stability in school attendance after ADF members had left service, with 55.2% having attended one school, and only 6.9% attending three or more schools.

Table 3.13 **Number of schools attended by school-age FWS children, stratified by military status of ADF member**

Measure	Military status of ADF member							
	All	Current			Ex-serving			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Number of schools attended during ADF member's service*	(n = 414)	(n = 304)			(n = 110)			0.18
1	17.6	52	17.1	(13.3 – 21.8)	21	19.1	(12.7 – 27.7)	
2	25.1	82	27.0	(22.3 – 32.3)	22	20.0	(13.5 – 28.7)	
3	19.8	63	20.7	(16.5 – 25.7)	19	17.3	(11.2 – 25.7)	
4	12.1	38	12.5	(9.2 – 16.7)	12	10.9	(6.2 – 18.4)	
5	12.1	36	11.8	(8.6 – 16.0)	14	12.7	(7.6 – 20.5)	
6+	13.3	33	10.9	(7.8 – 14.9)	22	20.0	(13.5 – 28.7)	
Number of schools attended after ADF member transitioned†					(n = 70)			
1					155	55.2	(41.9 – 67.7)	
2					97	37.9	(26.1 – 51.4)	
3+					19	6.9	(2.5 – 17.4)	

* Only asked of spouses/partners who had a school-age child who attended school during ADF members' service.

† Only asked of spouses/partners whose ADF member has left service and whose school-age child attended school during ADF members' service.

Note: 95% CI = 95% confidence interval.

3.2.6 Military service history and effects of military service

Military service history of ADF members, spouses/partners and their parents

This section reports on:

- the military service history of ADF members (e.g. whether deployed, whether the family was together during the deployment, and whether ADF members shared their deployment experiences with spouses/partners)
- whether spouses/partners had been members of the ADF and, if so, whether they had been deployed
- whether parents of FWS spouses/partners had been ADF members.

More than four in five ADF members had been deployed (85.0%), with rates not significantly differing across Current Serving or Ex-Serving ADF members (Table 3.14). Of all those who had been deployed, only 11.8% of families were not together during the deployment, with no significant differences between those who were Current Serving or Ex-Serving on this aspect. Of the ADF members who had been deployed, 39.7% had shared their deployment experiences with spouses/partners 'a little' and 33.4% 'somewhat'. Almost one in four (23.7%) had shared these experiences 'a lot'. Again, there were no significant differences between Current Serving and Ex-Serving ADF members on how much they had shared their deployment experiences.

Spouses/partners were also asked if they had served in the ADF or been deployed, with 17.5% having served and 48.0% of serving spouses/partners having been deployed. There were no significant differences between spouses/partners with Current Serving and Ex-Serving ADF members on their own military history.

Around one in five of all spouses/partners had a parent who had served in the ADF (19.9%), with significantly higher rates evident among those with Ex-Serving than Current Serving ADF members.

Table 3.14 Military service history of ADF members and spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
ADF member ever deployed	85.0	502	84.8	(81.7 – 87.5)	231	85.6	(80.8 – 89.3)	0.77
Not together during deployment*	11.8	51	10.3	(7.9 – 13.3)	35	15.2	(11.1 – 20.5)	0.06
ADF member's deployment experience was shared*								0.26
No	3.3	16	3.2	(2.0 – 5.2)	8	3.5	(1.7 – 6.8)	
A little	39.7	187	37.3	(33.2 – 41.7)	103	44.8	(38.4 – 51.3)	
Somewhat	33.4	173	34.5	(30.5 – 38.8)	71	30.9	(25.2 – 37.2)	
A lot	23.7	125	25.0	(21.3 – 28.9)	48	20.9	(16.1 – 26.7)	
Spouse/partner is a current or ex-ADF member								0.61
No	82.5	489	82.0	(78.7 – 84.9)	227	83.5	(78.5 – 87.4)	
Yes	17.5	107	18.0	(15.1 – 21.3)	45	16.5	(12.6 – 21.5)	
Spouse/partner ever deployed†	48.0	54	51.4	(41.8 – 61.0)	19	43.2	(29.0 – 58.6)	0.36
Parent was in ADF								0.002
No	80.1	493	83.0	(79.7 – 85.8)	201	73.9	(68.3 – 78.8)	
Yes	19.9	101	17.0	(14.2 – 20.3)	71	26.1	(21.2 – 31.7)	
Missing		2						

* Only asked of spouses/partners whose ADF member was deployed (All n = 868; Current n = 502; Ex-serving n = 231).

† Only asked of current or ex-ADF spouses/partners (All n = 152; Current n = 107; Ex-serving n = 45).

Note: 95% CI = 95% confidence interval.

Impact of military service on ADF members and spouses/partners

Spouses/partners were asked to rate the influence of their ADF members' military service on various aspects of ADF members' and their own lives, using the response options of 'a negative influence', 'no influence' and 'a positive influence'.

Spouses/partners felt there had been positive influences for the majority of ADF members on ADF members' financial situation (74.8%), career (71.7%), employment (69.5%) and physical health (54.1%). Positive influences outweighed negative ones on ADF members' relationships with spouses/partners, children, other immediate family members, and wider family and friends. Only on ADF members' mental health were

there more frequent negative than positive effects (48.3% compared with 33.1%). Figure 3.4 compares the influence of military service on Current Serving and Ex-Serving ADF members. Significant differences were found on employment, financial situation, careers, and physical and mental health, with a higher percentage of the Ex-Serving group being seen as negatively affected and a lower percentage positively affected than the Current Serving group (see Appendix D for details).

Looking next at the effect of ADF members' military service on civilian spouses/partners, only on their financial situation did a majority of all spouses/partners rate the influence as having been positive (57.1%). Between 42.8% and 60.0% said there had been no influence on relationships with other immediate family members, wider family, friends, and physical health. The largest negative effects were found on spouses'/partners' careers (53.6%), employment (53.1%) and mental health (43.3%). Comparison of the effects on spouses/partners with Current Serving and Ex-Serving ADF members revealed significant differences on their employment, careers and financial situation (as indicated in Figure 3.5). A higher percentage of those with Current Serving ADF members perceived there to be a negative influence on employment and careers. On the other hand, fewer of those with Ex-Serving ADF members perceived there to be a positive influence on their financial situation (see details in Appendix D).

Lastly, the influence of spouses'/partners' own military career on themselves was examined (n = 152, see Appendix D). A majority of these spouses/partners reported there had been a positive influence of their military service on their financial situation (70.3%), employment (66.7%), careers (60.8%), relationship with their ADF members (59.2%) and physical health (59.5%). The aspect on which the largest percentage reported a negative influence was their mental health (33.8%, although slightly more reported their mental health had been positively influenced, 40.0%). Comparison of FWS participants who were Current Serving or Ex-Serving ADF members revealed no significant differences on the degree to which their own military service was seen to have impacted on their own relationships, mental and physical wellbeing, and employment (Figure 3.6).

Figure 3.4 Perceived effect of ADF members’ service on ADF members, stratified by military status of ADF member



Figure 3.5 Perceived effect of ADF members’ service on civilian spouses/partners, stratified by military status of ADF member

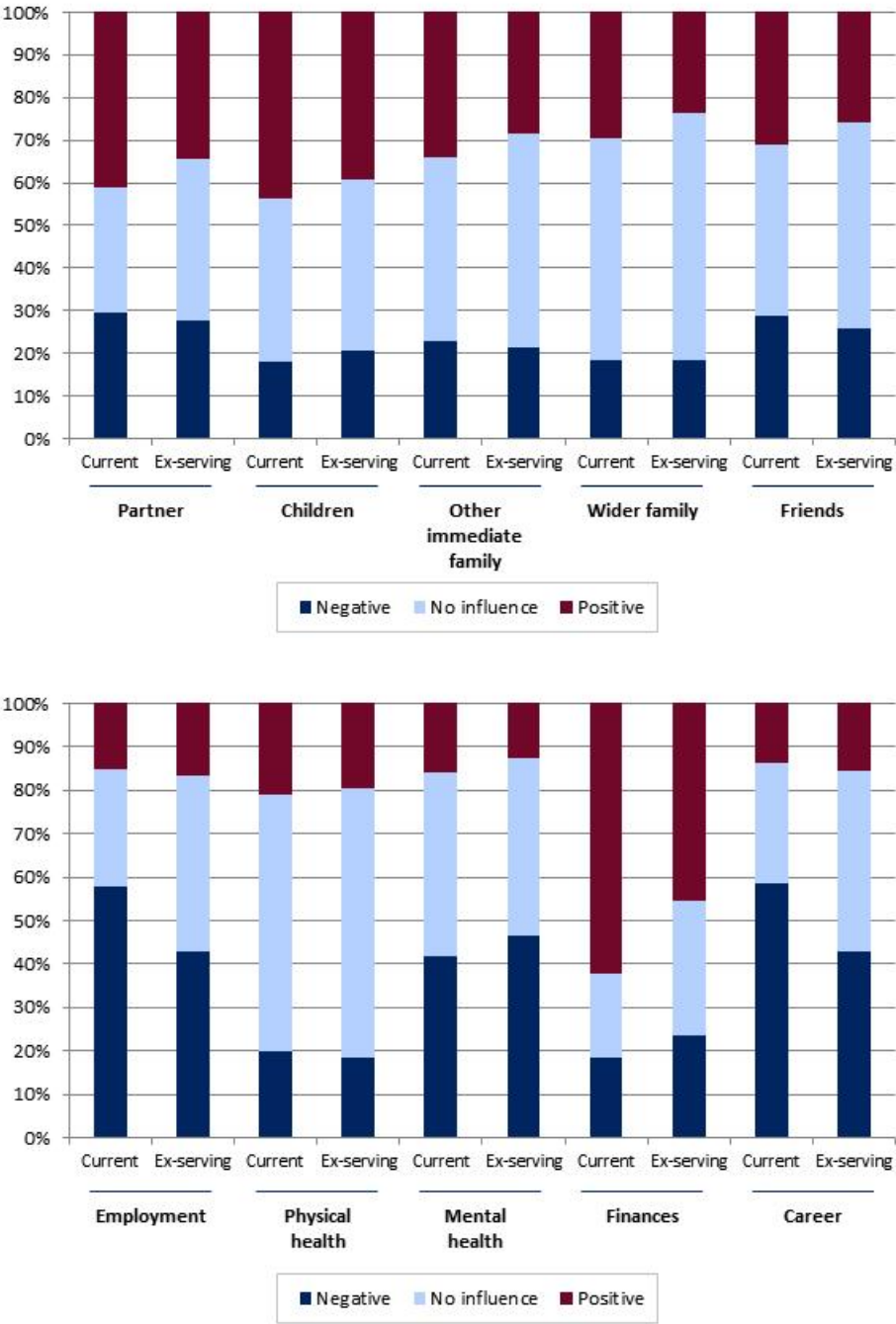
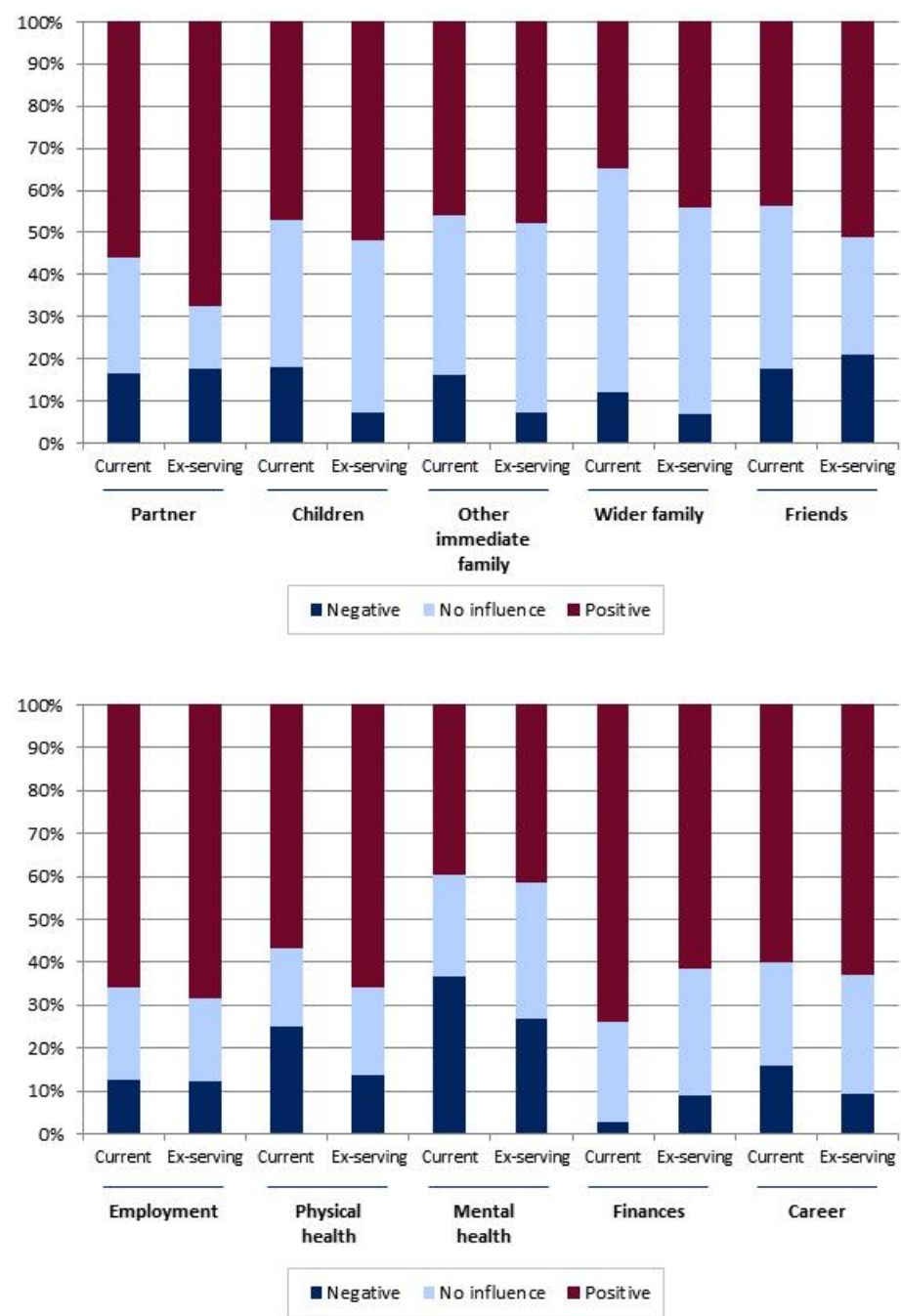


Figure 3.6 Perceived effect of spouses'/partners' own ADF military service on their wellbeing, stratified by military status of ADF member



3.2.7 Within-family wellbeing

Within-family wellbeing is another key area examined by the Family Wellbeing Study. While research shows that military families are generally resilient, as described in Chapter 1, there can be strains and difficulties for some. This section focuses on happiness and satisfaction in couple relationships as perceived by spouses/partners and ADF members; couple relationship quality and abuse in couple relationships; the parenting practices used by spouses/partners; and rates of behaviour problems among children aged 2 to 17 years.

Couple relationships

Current spouses/partners of ADF members were asked to describe the degree of happiness in their couple relationship using seven response options that were later recoded into unhappy and happy (see Chapter 2). Ex-spouses and ex-partners were not asked about their previous couple relationship and are therefore excluded from these analyses. Overall, approximately one in five spouses/partners reported their relationship as being unhappy (21.4%), with rates not significantly differing across those whose ADF members were Current Serving or Ex-Serving (Table 3.15). Spouses/partners were also asked about specific aspects of their relationship using the 7-item Relationship Assessment Scale (Hendrick, 1988; see Chapter 2 for details). There were significant differences when comparing the mean scores of spouses/partners of Current Serving and Ex-Serving ADF members, with levels tending to be less positive among those with Ex-Serving ADF members. Nevertheless, the mean scores for both groups were approximately 4, with the maximum possible score being 5, indicating relationships were generally high quality.

ADF members were asked to rate how satisfied or dissatisfied they were in their couple relationship, with cut-offs used to identify those who were dissatisfied (see Chapter 2). A total of 17.5% of all ADF members were dissatisfied, with rates not significantly differing across those who were Current Serving or Ex-Serving. Again, the mean scores for both groups were around 8 out of 10, indicating that most were satisfied with their relationship.

Abuse in couple relationships

Abuse at some time in couple relationships was measured using the Woman Abuse Screening Tool (Brown et al., 2000; see Chapter 2 for details) with all spouses/partners. The scale provides cut-offs by which to identify those who have experienced abuse at some stage of their couple relationship.

While most spouses/partners reported little or no abuse in their couple relationship, 4.8% had experienced abuse at some stage, with a significantly higher percentage of those with Ex-Serving than Current Serving ADF members having experienced abuse (8.4% compared with 3.1%) (Table 3.15). However, it should be noted that the mean

scores for both groups were between 10 and 11, only slightly above the lowest possible score of 8 but much lower than the maximum possible score of 24. Thus, the occurrence of abuse in couple relationships was very low overall, although was higher among those with Ex-Serving than Current Serving ADF members.

Table 3.15 Relationship quality according to spouses/partners and ADF members – abuse in relationships, stratified by military status of ADF member

Measure*	Military status of ADF member							
	All (n = 848)	Current (n = 582)			Ex-serving (n = 266)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
REPORTED BY SPOUSES/PARTNERS								
Unhappy relationship	21.4	118	20.4	(17.3 – 23.9)	63	23.7	(18.9 – 29.2)	0.28
Relationship quality (mean, SE)	0.03	4.22	0.03	(4.16 – 4.28)	4.08	0.05	(3.99 – 4.17)	0.01
REPORTED BY ADF MEMBERS								
Relationship satisfaction								
Score (mean, SE)	0.07	8.12	0.08	(7.97 – 8.28)	7.91	0.13	(7.66 – 8.16)	0.15
Dissatisfied	17.5	92	15.8	(13.1 – 19.0)	56	21.1	(16.6 – 26.5)	0.06
REPORTED BY SPOUSES/PARTNERS								
Abuse in relationships								
Score (mean, SE)	0.07	10.17	0.08	(10.01 – 10.33)	10.84	0.14	(10.56 – 11.12)	< 0.0001
Abusive relationship	4.8	18	3.1	(2.0 – 4.9)	22	8.4	(5.6 – 12.4)	0.001

* Only asked of those who were current spouses and partners; not asked of ex-spouses and ex-partners.
Note: 95% CI = 95% confidence interval. SE = standard error.

Parenting practices

ADF members with one or more children aged 2 to 17 years were asked about the number of dependent children they were living with in the Mental Health and Wellbeing Transition Study survey, and an algorithm was then used to randomly select one child whom they reported on for the MHWTS. The same child was reported on by spouses/partners for the FWS. Spouses/partners were asked questions about the parenting practices they were using with this child, and behaviour problems and competencies exhibited by the child.

Table 3.16 provides demographic details of the children that spouses/partners reported on (n = 698), including the child's sex, age and whether children were living with spouses/partners. There were similar proportions of boys and girls overall (52.1% were female), and there were no significant differences across the Current Serving and Ex-Serving groups on children's sex. The largest proportion of children were aged over 17 years (28.8%), with 10 to 17 years (26.9%) and 4 to 10 years (25.2%) the next most frequent. The children that spouses/partners of Ex-Serving ADF members reported on tended to be older (Table 3.16); for example, a higher percentage was aged over 17 years (39.4%) than in families with Current Serving ADF members (24.1%). Also,

significantly fewer were still living in the family home (68.5%, compared with 82.3% of Current Serving ADF members).

Table 3.16 Child demographics, stratified by military status of ADF member

Measure*	Military status of ADF member							
	All (n = 698)	Current (n = 485)			Ex-serving (n = 214)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Female	52.1	254	52.4	(47.9 – 56.8)	110	51.6	(44.9 – 58.3)	0.86
Age								0.001
< 2 years	6.2	29	6.0	(4.2 – 8.5)	14	6.6	(3.9 – 10.8)	
≥ 2 – ≤ 4 years	12.9	68	14.0	(11.2 – 17.4)	22	10.3	(6.9 – 15.2)	
> 4 – ≤ 10 years	25.2	134	27.6	(23.8 – 31.8)	42	19.7	(14.9 – 25.7)	
> 10 – ≤ 17 years	26.9	137	28.2	(24.4 – 32.4)	51	23.9	(18.6 – 30.2)	
> 17 years	28.8	117	24.1	(20.5 – 28.1)	84	39.4	(33.0 – 46.2)	
Lives with family member	78.1	399	82.3	(78.6 – 85.4)	146	68.5	(61.9 – 74.5)	< 0.0001

* Only asked of spouses/partners who have children with ADF member.

Note: 95% CI = 95% confidence interval.

The subset of parents with children aged less than 18 years old (n = 497) were asked about their parenting practices, with the measures used capturing the major parenting dimensions of self-efficacy (how spouses/partners felt they were going as parents), consistency, hostility, use of reasoning, and warmth (see Chapter 2 for details).

Table 3.17 shows that spouses/partners of Current Serving ADF members reported being significantly more consistent than their counterparts whose ADF members were Ex-Serving, although group mean scores were around 4, near the maximum possible score of 5, indicating that most were highly consistent. There were no significant differences between the spouses/partners of Current Serving and Ex-Serving ADF members on the other parenting measures (parenting self-efficacy, hostility, use of reasoning, and warmth).

Table 3.17 Spouses'/partners' parenting practices, stratified by military status of ADF member

Measure*	Military status of ADF member								
	All (n = 497)		Current (n = 368)			Ex-serving (n = 129)			p-value
	Mean	SE	Mean	SE	(95% CI)	Mean	SE	(95% CI)	
Self-efficacy	4.05	0.04	4.04	0.04	(3.96 – 4.13)	4.09	0.08	(3.93 – 4.24)	1.00
Consistency	4.20	0.03	4.23	0.03	(4.16 – 4.30)	4.03	0.07	(3.90 – 4.17)	0.01
Hostility	1.85	0.03	1.81	0.03	(1.76 – 1.87)	1.90	0.05	(1.79 – 2.01)	0.15
Inductive reasoning	4.18	0.04	4.17	0.04	(4.09 – 4.25)	4.02	0.08	(3.86 – 4.19)	0.35
Warmth	4.27	0.03	4.27	0.03	(4.20 – 4.34)	4.19	0.07	(4.05 – 4.32)	0.54

* Only asked of spouses/partners who have children with ADF member age < 18 years.

Note: 95% CI = 95% confidence interval. SE = standard error.

Child behaviour problems and competencies

The final aspect of family wellbeing examined was the level of behaviour problems and competencies exhibited by children as reported by spouses/partners. Other research has suggested that levels can be higher among military children than in the general child population, as reviewed in Chapter 1.

The FWS used the 25-item Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1995; see Chapter 2 for details). The SDQ measures emotional symptoms, conduct problems, hyperactivity problems, peer problems, prosocial behaviour, and total behaviour problems. Cut-offs are provided to identify children in the normal, borderline and abnormal range. It is anticipated that 10% of a community sample would score in the abnormal range on any given scale, and a further 10% would score as borderline.

Table 3.18 shows the percentage of children scoring in the abnormal range on the various sub-scales and total score. Across all children aged 2 to 17 years, 11.8% were in the abnormal range on total behaviour problems, slightly higher than the rate expected in a community sample. Types of child behaviour problems that were above the expected rate were peer problems (17.5%), emotional symptoms (16.9%) and hyperactivity (15.8%). On the other hand, only a small percentage (and fewer than would be expected normatively) was showing low levels of prosocial behaviour (5.3%). There were significant differences between children of Current Serving and Ex-Serving ADF members on rates of hyperactivity, with the prevalence being greater among children of Current Serving ADF members (18.1% compared with 8.8%). No other significant differences on behaviour problems or prosocial behaviour were found when comparing children of Current Serving and Ex-Serving ADF members.

Table 3.18 Socio-emotional adjustment of children aged 2 to 17 years, stratified by military status of ADF member

Measure*	Military status of ADF member							p-value
	All (n = 454)	Current (n = 339)			Ex-serving (n = 115)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Total problems	11.8	40	11.9	(8.8 – 15.8)	13	11.5	(6.7 – 18.9)	0.92
Emotional symptoms	16.9	61	18.0	(14.3 – 22.5)	12	10.6	(6.1 – 17.9)	0.06
Conduct problems	9.8	32	9.5	(6.8 – 13.1)	12	10.6	(6.1 – 17.9)	0.72
Hyperactivity problems	15.8	61	18.1	(14.3 – 22.6)	10	8.8	(4.8 – 15.8)	0.02
Peer problems	17.5	57	16.9	(13.2 – 21.3)	22	19.5	(13.1 – 27.9)	0.53
Low prosocial behaviour	5.3	20	5.9	(3.8 – 9.0)	< 5	3.5	(1.3 – 9.2)	0.33

* Only asked of spouses/partners who have children with ADF member aged between 2 and 17 years.
Note: 95% CI = 95% confidence interval.

3.2.8 Spouses'/partners' health

Physical health and quality of life

Spouses/partners were asked to rate their general physical health over the 12 months using the response categories of 'excellent', 'good', 'fair', 'poor' and 'very poor'. A total of 13.7% of all spouses/partners reported having had poor or very poor general physical health in this time period, with no significant differences between those with Current Serving and Ex-Serving ADF members (Table 3.19). They were also asked to rate their current quality of life using response options of 'very good', 'good', 'neither good nor poor', 'poor' and 'very poor'. Very few reported a poor or very poor quality of life (2.2% over all spouses/partners) and again, there were no significant differences between those with Current Serving and Ex-Serving ADF members.

Table 3.19 Spouses'/partners' physical health and quality of life, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Poor physical health	13.7	85	14.3	(11.7 – 17.3)	34	12.5	(9.1 – 17.1)	0.49
Poor quality of life	2.2	15	2.5	(1.5 – 4.1)	< 5	1.5	(0.5 – 3.9)	0.33

Note: 95% CI = 95% confidence interval.

Exposure to trauma

Information on spouses'/partners' lifetime exposure to 10 differing types of traumatic events was collected, as well as the total number of these events experienced (Table 3.20). The most common traumatic event reported was having someone close to them die unexpectedly, with 50.8% having had this experience. Other traumas experienced by 10.0% or more included (in order of occurrence) witnessing the serious injury or death of a person (22.3%), sexual assault (18.0%), witnessing serious physical fights at home as a child (11.3%), having someone close to them experience a traumatic event (10.5%), experiencing a life-threatening illness (10.0%), and experiencing another unspecified type of traumatic event (10.2%). Altogether, approximately three in four spouses/partners had experienced one or more of these traumatic events in their lifetime (73.7%). Comparison of those whose ADF members were Current Serving or Ex-Serving revealed significant differences only on being involved in a life-threatening car accident, with rates higher among those with an Ex-Serving ADF member (12.7% compared with 6.8%). These differences could at least partly be due to the older age of this group, reflecting the longer time available for this traumatic event to have occurred. There were also no significant differences on the total number of traumatic events experienced.

Table 3.20 Spouses/partners' exposure to trauma, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Type of trauma experienced								
Someone close to you died unexpectedly	50.8	288	49.0	(44.9 – 53.0)	147	54.9	(48.8 – 60.7)	0.11
Saw someone being badly injured or killed	22.3	127	21.6	(18.4 – 25.1)	64	23.9	(19.1 – 29.4)	0.46
Was involved in a life-threatening car accident	8.6	40	6.8	(5.0 – 9.2)	34	12.7	(9.2 – 17.3)	0.005
Was mugged, held up or threatened with a weapon	8.5	50	8.5	(6.5 – 11.1)	23	8.6	(5.8 – 12.6)	0.97
Experienced a life-threatening illness	10.0	57	9.7	(7.5 – 12.4)	29	10.8	(7.6 – 15.2)	0.61
Witnessed serious physical fights at home as a child	11.3	69	11.7	(9.4 – 14.6)	28	10.4	(7.3 – 14.7)	0.58
Was sexually assaulted	18.0	105	17.9	(15.0 – 21.2)	49	18.3	(14.1 – 23.4)	0.88
Was involved in a major national disaster (e.g. earthquake)	9.0	58	9.9	(7.7 – 12.6)	19	7.1	(4.6 – 10.9)	0.19
Their child had a life-threatening illness or injury	7.8	44	7.5	(5.6 – 9.9)	23	8.6	(5.8 – 12.6)	0.58
Someone close to them experienced a very traumatic event	10.5	61	10.4	(8.1 – 13.1)	29	10.8	(7.6 – 15.2)	0.84
Other	10.2	62	10.5	(8.3 – 13.3)	25	9.3	(6.4 – 13.5)	0.59
Total number of traumatic event types experienced								0.58
None	26.3	164	27.9	(24.4 – 31.7)	61	22.8	(18.1 – 28.2)	
1	27.6	157	26.7	(23.3 – 30.4)	79	29.5	(24.3 – 35.3)	
2	20.3	120	20.4	(17.3 – 23.9)	54	20.1	(15.7 – 25.4)	
3	13.8	78	13.3	(10.7 – 16.3)	40	14.9	(11.1 – 19.7)	
4+	12.0	69	11.7	(9.4 – 14.6)	34	12.7	(9.2 – 17.3)	

Note: 95% CI = 95% confidence interval.

Risky behaviours

To assess alcohol use, a series of questions from the Alcohol Use Disorders Identification Test (AUDIT) was used (Saunders et al., 1993; see Chapter 2). The criterion of an AUDIT score of 8 or higher was used to identify problem drinking. Illicit drug use was assessed by questions asking whether FWS participants had used illicit drugs in their lifetime and in the past 12 months (see Chapter 2 for details), with any type of illicit drug use used to denote illicit drug use. It should be noted that Current Serving ADF spouses/partners were not asked about illicit drugs use as it is prohibited and leads to instant dismissal. They are therefore excluded from analyses of illicit drug use. The Problem Gambling Severity Index (Volberg & Williams, 2012; Miller et al.,

2013; see Chapter 2) was used to assess engagement in gambling and signs of problematic gambling behaviours.

Table 3.21 shows that 10.0% of all spouses/partners were drinking at levels that could be classified as problematic. There were no significant differences on problematic alcohol use between spouses/partners of Current Serving and Ex-Serving ADF members. A total of 18.5% of all spouses/partners had used illicit drugs in their lifetime (excluding spouses/partners who were Current Serving ADF members) and 2.0% had used illicit drugs in the past 12 months. No significant differences on lifetime illicit drug use were found between those with Current Serving and Ex-Serving ADF members, but there were significant differences on recent illicit drug use (in the past 12 months), with this more common among those with Ex-Serving ADF members, although rates were very low overall. With regard to gambling, 28.4% of all spouses/partners had gambled at least once in the past 12 months, while 2.7% had shown signs of gambling problems. Significantly more spouses/partners of Ex-Serving ADF members had gambled in the past 12 months (34.3% compared with 25.8% whose ADF members were Current Serving). However, there were no significant differences on the percentage showing signs of problem gambling.

Table 3.21 Spouses'/partners' involvement in risk-taking, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Problem drinking								
Score (mean, SE)	0.13	3.44	0.15	(3.14 – 3.74)	3.86	0.22	(3.42 – 4.30)	0.12
Problem drinker	10.0	51	8.8	(6.7 – 11.4)	34	12.6	(9.2 – 17.2)	0.08
Illicit drug use: ever*	18.5	108	18.3	(15.4 – 21.6)	51	18.8	(14.6 – 24.0)	0.86
Illicit drug use: last 12 months*	2.0	6	1.0	(0.5 – 2.2)	11	4.1	(2.3 – 7.3)	0.003
Gambled in last 12 months	28.4	152	25.8	(22.4 – 29.5)	92	34.3	(28.9 – 40.3)	0.01
Problem gambling								
Score (mean, SE)	0.02	0.06	0.02	(0.02 – 0.10)	0.14	0.06	(0.03 – 0.26)	0.09
Problem gambling	2.7	13	2.2	(1.3 – 3.8)	10	3.8	(2.0 – 6.9)	0.19

* Analyses conducted on spouses/partners who are not currently serving in the ADF (All n = 815; Current n = 553; Ex-serving n = 262).
Note: 95% CI = 95% confidence interval. SE = standard error.

Spouses'/partners' mental health problems

Various self-report measures were used to assess spouses'/partners' current mental health problems. Psychological distress was measured using the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002; see Chapter 2 for details). The K10 provides norms to identify two groups: (1) those experiencing 'high' to 'very high' psychological distress in the past four weeks; and (2) those experiencing 'no' to 'moderate' psychological distress in the same time period. Symptoms of PTSD were

assessed using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers et al., 1993; see Chapter 2). Respondents who had experienced one or more traumatic events in their lifetime (n = 631) were asked about whether they had experienced PTSD symptoms in the past month. The scale provides a cut-off which was used to identify those with high levels of PTSD symptoms (severe enough to lead to a probable PTSD diagnosis). Twelve-month suicidal ideation and behaviour was assessed via four items that looked specifically at suicidal thoughts, plans and attempts. Those respondents who answered ‘yes’ to any of four items were considered to have shown signs of suicidality. We also show separately the percentage who reported suicidal plans or attempts.

Overall, 16.8% of all spouses/partners were classified as experiencing high to very high levels of psychological distress, with rates not significantly different across those with Current Serving and Ex-Serving ADF members (Table 3.22). Around one in ten were identified as having severe levels of PTSD symptoms in the past four weeks (11.1%). Again, this did not significantly differ across those with Current Serving and Ex-Serving ADF members. Approximately 13.4% of all spouses/partners had shown signs of suicidality in the past 12 months (i.e. had suicidal thoughts, or made a plan or attempt), but only 1.5% had made a plan or attempted suicide. Spouses/partners of Ex-Serving ADF members were significantly more likely to have shown signs of suicidality in the past 12 months than those with Current Serving ADF members (18.3% compared with 11.1%), but there were no significant differences on suicide plans/attempts.

Table 3.22 Spouses’/partners’ mental health, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Psychological distress								
Score (mean, SE)	0.23	16.12	0.28	(15.57 – 16.66)	16.44	0.42	(15.61 – 17.27)	0.51
High/very high	16.8	94	16.2	(13.4 – 19.4)	48	18.3	(14.0 – 23.4)	0.46
PTSD*								
Score (mean, SE)	0.52	27.39	0.62	(26.17 – 28.61)	28.80	0.95	(26.93 – 30.68)	0.20
High PTSD symptoms	11.1	45	10.7	(8.1 – 14.1)	24	11.8	(8.0 – 17.1)	0.69
Suicidality	13.4	64	11.1	(8.8 – 14.0)	48	18.3	(14.1 – 23.5)	0.004
Made a plan or attempted suicide	1.5	10	1.7	(0.9 – 3.2)	< 5	1.1	(0.4 – 3.5)	0.52

* Only asked of spouses/partners who had experienced 1+ traumatic events (All n = 631; Current n = 424; Ex-serving n = 207).
Note: 95% CI = 95% confidence interval. SE = standard error.

Spouses/partners were also asked whether they had ever felt concerned about their own mental health, when they had first become concerned, and whether they had sought help (Table 3.23). Approximately half (54.4%) had been concerned about their mental health at some time in their life. Of those who had been concerned, they had

first become concerned on average 9.5 years ago. Approximately three-quarters of those who had been concerned had sought help (78.2%), with 49.0% doing so within three months of becoming concerned and 15.1% within one year. However, 21.8% had never sought help for their concerns. Almost all of those who had concerns knew where to obtain help (86.6%) and for 13.8%, a family member had facilitated access to help. No significant differences were found on rates of mental health concerns or seeking help for these concerns when comparing spouses/partners with a Current Serving or Ex-Serving ADF member.

Table 3.23 Spouses'/partners' concerns about their own mental health, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned own mental health	54.4	316	55.1	(51.0 – 59.2)	139	52.7	(46.6 – 58.6)	0.50
Number of years since first concerned about own mental health*								
Number of years (mean, SE)	0.4	9.6	0.5	(8.6 – 10.5)	9.5	0.7	(8.2 – 10.8)	0.92
Number of years								0.94
≤1 year	8.6	28	9.3	(6.5 – 13.2)	9	7.0	(3.6 – 13.0)	
2 years	10.3	31	10.3	(7.3 – 14.3)	13	10.1	(5.9 – 16.7)	
3 years	9.6	26	8.7	(6.0 – 12.4)	15	11.6	(7.1 – 18.5)	
4 years	6.3	18	6.0	(3.8 – 9.3)	9	7.0	(3.6 – 13.0)	
5–9 years	27.0	83	27.7	(22.9 – 33.0)	33	25.6	(18.7 – 33.9)	
10–19 years	26.3	78	26.0	(21.3 – 31.3)	35	27.1	(20.1 – 35.6)	
20+ years	11.9	36	12.0	(8.8 – 16.2)	15	11.6	(7.1 – 18.5)	
Missing		16			10			
First sought help for own mental health problems*								0.45
Within 3 months of becoming concerned	49.0	160	51.0	(45.4 – 56.5)	60	44.4	(36.2 – 53.0)	
Within 1 year of becoming concerned	15.1	43	13.7	(10.3 – 18.0)	25	18.5	(12.8 – 26.1)	
More than 1 year after becoming concerned	14.0	45	14.3	(10.9 – 18.7)	18	13.3	(8.5 – 20.3)	
Did not seek help	21.8	66	21.0	(16.8 – 25.9)	32	23.7	(17.2 – 31.7)	
Last sought help for own mental health problems*								0.61
Currently seeking help	23.4	70	22.3	(18.0 – 27.3)	35	25.9	(19.2 – 34.1)	
Not currently, but in last 12 months	13.6	46	14.6	(11.1 – 19.0)	15	11.1	(6.8 – 17.7)	
Not currently, but 12+ months ago	42.5	136	43.3	(37.9 – 48.9)	55	40.7	(32.7 – 49.3)	
Never sought help	20.5	62	19.7	(15.7 – 24.5)	30	22.2	(15.9 – 30.1)	
Knew where to get help for their own mental health problems†	86.6	218	87.9	(83.2 – 91.4)	86	83.5	(74.9 – 89.6)	0.27
Family member contacted someone to get help for them‡	13.8	34	15.6	(11.3 – 21.1)	8	9.3	(4.7 – 17.7)	0.15

* Only asked of spouses/partners who were concerned about own mental health (All n = 455; Current n = 316; Ex-serving n = 139).

† Only asked of spouses/partners who have ever sought help for own mental health (All n = 351; Current n = 248; Ex-Serving n = 103).

‡ Only asked of spouses/partners who knew where to get help (All n = 304; Current n = 218; Ex-serving n = 86).

Note: 95% CI = 95% confidence interval. SE = standard error.

The spouses/partners who were concerned about their mental health were then asked about the types of problems that had led them to seek help (n = 351; Table 3.24). The most common problems that had led to help seeking were depression (70.1%), anxiety (65.0%), sleep problems (34.8%) and relationship problems (33.0%), noting that these

figures are based on a subset of spouses/partners only (those who had sought help). No significant differences were found between those with a Current Serving or Ex-Serving ADF member on the types of problems that had led them to seek help.

Table 3.24 Types of problems leading to help seeking among spouses/partners who expressed concerns about their mental health and had sought help, stratified by military status of ADF member

Problems that led family member to seek help for themselves*	Military status of ADF member							
	All (n = 351)	Current (n = 248)			Ex-serving (n = 103)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Anger	21.1	56	22.6	(17.8 – 28.2)	18	17.5	(11.2 – 26.2)	0.29
Anxiety	65.0	160	64.5	(58.3 – 70.3)	68	66.0	(56.2 – 74.6)	0.79
Relationship problems	33.0	79	31.9	(26.3 – 38.0)	37	35.9	(27.1 – 45.8)	0.46
Nightmares	10.0	28	11.3	(7.9 – 15.9)	7	6.8	(3.2 – 13.7)	0.20
Depression	70.1	175	70.6	(64.6 – 75.9)	71	68.9	(59.2 – 77.2)	0.76
Alcohol or drug problems	4.3	10	4.0	(2.2 – 7.4)	5	4.9	(2.0 – 11.3)	0.73
Sleep	34.8	90	36.3	(30.5 – 42.5)	32	31.1	(22.8 – 40.8)	0.35
Pain	6.8	16	6.5	(4.0 – 10.3)	8	7.8	(3.9 – 14.9)	0.66
Problems at work	14.5	36	14.5	(10.6 – 19.5)	15	14.6	(8.9 – 22.9)	0.99
Other	18.2	47	19.0	(14.5 – 24.4)	17	16.5	(10.4 – 25.1)	0.59

* Only asked of spouses/partners who have concerns about own mental health and sought help.

Note: 95% CI = 95% confidence interval.

Those who had been concerned about their mental health (n = 455) were also asked whether they had been diagnosed as having a mental health condition by a medical doctor during their lifetime and in the past 12 months, or had not received a diagnosis (Table 3.25). During their lifetime, 43.9% of those who expressed concerns had been diagnosed with depression, 37.9% with anxiety, and 8.7% with PTSD. Approximately one in five had been diagnosed as having depression in the past 12 months (21.7%), and a similar percentage as having anxiety (20.3%), with 5.4% receiving a diagnosis of PTSD in this time frame. Looking next at the proportion who experienced these types of problems but had not received a diagnosis, rates were 27.5% for anxiety/stress, 24.8% for depression and 7.7% for PTSD (this subset included those who had not sought help as well as those who sought help but did not receive a diagnosis). No significant differences were found on rates of diagnosed and non-diagnosed mental health conditions between spouses/partners of Current Serving or Ex-Serving ADF members.

Table 3.25 Types of diagnosed mental health conditions, stratified by military status of ADF member

Measure*	Military status of ADF member							
	All (n = 455)	Current (n = 316)			Ex-serving (n = 139)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Mental health condition diagnosed/treated by a medical doctor: ever								
Alcohol abuse or dependency	1.3	< 5	1.3	(0.5 – 3.4)	< 5	1.5	(0.4 – 5.8)	0.86
Anxiety or stress	37.9	115	36.6	(31.4 – 42.1)	55	40.7	(32.7 – 49.3)	0.41
Depression	43.9	135	43.0	(37.6 – 48.6)	62	45.9	(37.6 – 54.5)	0.57
PTSD	8.7	30	9.6	(6.7 – 13.4)	9	6.7	(3.5 – 12.4)	0.32
Other psychiatric/ psychological condition needing treatment/counselling	5.8	17	5.4	(3.4 – 8.6)	9	6.7	(3.5 – 12.4)	0.60
Mental health condition diagnosed/treated by a medical doctor: last 12 months								
Alcohol abuse or dependency	0.4	< 5	0.3	(0.0 – 2.2)	< 5	0.7	(0.1 – 5.2)	0.54
Anxiety or stress	20.3	59	18.8	(14.9 – 23.6)	32	23.7	(17.2 – 31.7)	0.24
Depression	21.7	67	21.5	(17.2 – 26.4)	30	22.4	(16.0 – 30.3)	0.83
PTSD	5.4	18	5.8	(3.6 – 9.0)	6	4.4	(2.0 – 9.6)	0.57
Other psychiatric/ psychological condition needing treatment/counselling	3.3	9	2.9	(1.5 – 5.4)	6	4.4	(2.0 – 9.6)	0.39
Self-reported mental health conditions not diagnosed/treated by a medical doctor								
Alcohol abuse or dependency	6.6	20	6.3	(4.1 – 9.6)	10	7.2	(3.9 – 12.9)	0.73
Anxiety or stress	27.5	87	27.5	(22.9 – 32.7)	38	27.3	(20.5 – 35.4)	0.97
Depression	24.8	79	25.0	(20.5 – 30.1)	34	24.5	(18.0 – 32.4)	0.90
PTSD	7.7	23	7.3	(4.9 – 10.7)	12	8.6	(4.9 – 14.7)	0.62
Other psychiatric/ psychological condition needing treatment/counselling	4.0	15	4.7	(2.9 – 7.7)	< 5	2.2	(0.7 – 6.6)	0.19

* Only asked of spouses/partners who have concerns about own mental health.

Note: 95% CI = 95% confidence interval.

3.2.9 Sources of help for mental health problems

All spouses/partners were asked about sources they had used to gain information about or access to mental health services. The most frequent avenue used was the beyondblue website (7.4%), with the Veterans and Veterans Families Counselling Service (VVCS) Veterans Line (4.7%) and social media such as Facebook or Twitter (3.9%) being the next most frequent sources used, while 3.6% had used the Department of Veterans' Affairs website and 3.6% another unspecified type of website. Those with Current Serving or Ex-Serving ADF members did not significantly differ on the types of sources used, except that those with Current Serving ADF members had significantly more often used 'other' health websites and the Defence Community Organisation (Table 3.26). However, the numbers were too small to reliably identify differences between spouses/partners of Current Serving and Ex-Serving ADF members.

Table 3.26 Self-help sources used by spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
ADF website	3.0	20	3.5	(2.3 – 5.4)	5	1.9	(0.8 – 4.5)	0.21
DVA website	3.6	19	3.3	(2.1 – 5.1)	11	4.2	(2.3 – 7.4)	0.54
At Ease website	0.2	< 5	0.3	(0.1 – 1.4)	< 5	0.0		1.00*
Black Dog Institute website	2.6	15	2.6	(1.6 – 4.3)	7	2.7	(1.3 – 5.5)	0.98
Headspace website	1.4	8	1.4	(0.7 – 2.8)	< 5	1.5	(0.6 – 4.0)	0.89
Beyondblue website	7.4	41	7.2	(5.3 – 9.6)	21	8.0	(5.2 – 11.9)	0.68
Mindhealthconnect website	0.1	< 5	0.2	(0.0 – 1.2)	< 5	0.0		1.00*
Lifeline website	0.6	< 5	0.5	(0.2 – 1.6)	< 5	0.8	(0.2 – 3.0)	0.68
Kids Helpline website	0.2	< 5	0.3	(0.1 – 1.4)	< 5	0.0		1.00*
MensLine website	0.2	< 5	0.2	(0.0 – 1.2)	< 5	0.4	(0.1 – 2.7)	0.57
Other health website	3.1	15	2.6	(1.6 – 4.3)	11	4.2	(2.3 – 7.4)	0.23
Moodgym internet treatment	0.7	< 5	0.7	(0.3 – 1.9)	< 5	0.8	(0.2 – 3.0)	0.92
E-couch internet treatment	0.2	< 5	0.3	(0.1 – 1.4)	< 5	0.0		1.00*
Other internet treatment	1.1	< 5	0.7	(0.3 – 1.9)	5	1.9	(0.8 – 4.5)	0.12
A self-help group	0.4	< 5	0.5	(0.2 – 1.6)	< 5	0.0		0.56*
PTSD Coach Australia smartphone app	0.7	5	0.9	(0.4 – 2.1)	< 5	0.4	(0.1 – 2.7)	0.43
On Track smartphone app	0.1	< 5	0.2	(0.0 – 1.2)	< 5	0.0		1.00*
Other smartphone app	1.2	6	1.0	(0.5 – 2.3)	< 5	1.5	(0.6 – 4.0)	0.56
Email subscriptions/mailling list	0.1	< 5	0.0		< 5	0.4	(0.1 – 2.7)	0.32*
Blogs	1.0	5	0.9	(0.4 – 2.1)	< 5	1.1	(0.4 – 3.5)	0.72
Social media (i.e. Facebook, Twitter)	3.9	21	3.7	(2.4 – 5.6)	12	4.5	(2.6 – 7.9)	0.54
Defence Family Helpline	1.3	8	1.4	(0.7 – 2.8)	< 5	1.1	(0.4 – 3.5)	0.76
ADF All-hours Support Line	0.4	< 5	0.2	(0.0 – 1.2)	< 5	0.8	(0.2 – 3.0)	0.19
VVCS Veterans Line	4.7	28	4.9	(3.4 – 7.0)	11	4.2	(2.3 – 7.4)	0.65
1800 IMSICK	0.7	< 5	0.5	(0.2 – 1.6)	< 5	1.1	(0.4 – 3.5)	0.33
Lifeline	0.5	< 5	0.5	(0.2 – 1.6)	< 5	0.4	(0.1 – 2.7)	0.78
MensLine	0.2	< 5	0.3	(0.1 – 1.4)	< 5	0.0		1.00*
MindSpot Clinic helpline	0.1	< 5	0.2	(0.0 – 1.2)	< 5	0.0		1.00*
Relationships Australia helpline	1.1	7	1.2	(0.6 – 2.5)	< 5	0.8	(0.2 – 3.0)	0.55
SANE Australia helpline	0.5	< 5	0.2	(0.0 – 1.2)	< 5	1.1	(0.4 – 3.5)	0.06
Other unspecified helpline	3.6	26	4.5	(3.1 – 6.6)	< 5	1.5	(0.6 – 4.0)	0.03
An ex-service organisation	1.5	10	1.7	(0.9 – 3.2)	< 5	1.1	(0.4 – 3.5)	0.51
Defence Community Organisation	3.0	23	4.0	(2.7 – 6.0)	< 5	0.8	(0.2 – 3.0)	0.01
Defence Families of Australia	1.3	10	1.7	(0.9 – 3.2)	< 5	0.4	(0.1 – 2.7)	0.11

* Fisher's exact test.

Note: 95% CI = 95% confidence interval.

Barriers to assistance for mental health problems

A total of 98 spouses/partners had not sought help for their mental health concerns. These participants were asked about the factors that may have prevented them from seeking help, including perceived barriers and stigma (Table 3.27). The most common reasons chosen were feeling that they could still function effectively (91.7%), followed by preferring to manage their problems by themselves (79.8%). Other reasons chosen by approximately one-third were obtaining help from another source (37.5%), thinking that nothing could help (35.5%), or being afraid to ask for help or concerned about what others would think of them (34.4%). A further 23.4% could not financially afford to seek help. No significant differences were found on the types of barriers experienced by those with Current Serving or Ex-Serving ADF members.

Table 3.27 Spouses'/partners' perceived barriers and stigmas to receiving care for own mental health problems, stratified by military status of ADF member

Measure*	Military status of ADF member							
	All (n = 98)	Current (n = 66)			Ex-serving (n = 32)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
I preferred to manage myself	79.8	53	84.1	(72.6 – 91.4)	22	71.0	(51.8 – 84.8)	0.14
I did not think anything could help	35.5	23	37.1	(25.8 – 50.0)	10	32.3	(17.7 – 51.4)	0.65
I didn't know where to get help	14.9	10	15.4	(8.3 – 26.6)	< 5	12.9	(4.6 – 31.1)	0.75
I was afraid to ask for help, or of what others would think of me if I did	34.4	24	36.9	(25.9 – 49.5)	9	29.0	(15.2 – 48.2)	0.45
I could not afford it	23.4	13	20.3	(12.0 – 32.3)	9	30.0	(15.8 – 49.5)	0.30
I can still function effectively	91.7	59	92.2	(82.2 – 96.8)	29	90.6	(73.3 – 97.1)	0.79
I got help from another source	37.5	24	37.5	(26.3 – 50.2)	12	37.5	(22.0 – 56.1)	1.00

* Only asked of spouses/partners who never sought help for their own mental health concerns.
Note: 95% CI = 95% confidence interval.

3.2.10 ADF members' mental health problems

Concerns about ADF members' mental health and assistance provided

Spouses/partners were asked whether they had ever been concerned about the mental health of their ADF members; how long they had felt concerned; whether they had provided assistance; the types of assistance provided; and whether ADF members had sought help as a result of the encouragement of their spouses/partners.

Overall, 58.7% of all spouses/partners had been concerned about the mental health of their ADF members at some time, with them first becoming concerned on average 6.7 years ago (Table 3.28). Significantly more spouses/partners of Ex-Serving ADF members had been concerned about their ADF member's mental health than those with Current Serving ones (71.2% compared with 53.0% respectively), and had first become concerned on average 7.8 years ago, significantly longer than

spouses/partners of Current Serving ADF members, who had first become concerned on average 6.1 years ago.

Table 3.28 Concerns about ADF members' mental health reported by spouses/partners – assistance provided, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned about ADF member's mental health	58.7	305	53.0	(48.9 – 57.0)	188	71.2	(65.4 – 76.4)	< 0.0001
Number of years since first concerned about ADF member's mental health*								
Number of years (mean, SE)	0.2	6.1	0.3	(5.6 – 6.6)	7.8	0.4	(6.9 – 8.7)	0.0008
Number of years								0.001
≤1 year	7.5	31	10.2	(7.2 – 14.1)	6	3.2	(1.4 – 7.0)	
2 years	12.2	44	14.4	(10.9 – 18.9)	16	8.5	(5.3 – 13.5)	
3 years	13.0	46	15.1	(11.5 – 19.6)	18	9.6	(6.1 – 14.7)	
4 years	10.7	28	9.2	(6.4 – 13.0)	25	13.3	(9.1 – 19.0)	
5–9 years	34.1	92	30.2	(25.2 – 35.6)	76	40.4	(33.6 – 47.7)	
10+ years	22.5	64	21.0	(16.8 – 25.9)	47	25.0	(19.3 – 31.7)	
Provided assistance for ADF member's mental health*								0.07
Currently providing assistance	31.9	89	29.3	(24.4 – 34.7)	68	36.2	(29.6 – 43.3)	
In last 12 months	18.5	50	16.4	(12.7 – 21.1)	41	21.8	(16.4 – 28.3)	
12+ months ago	23.2	77	25.3	(20.7 – 30.6)	37	19.7	(14.6 – 26.0)	
Never provided assistance	26.4	88	28.9	(24.1 – 34.3)	42	22.3	(16.9 – 28.9)	
Assistance included encouraging ADF member to get help for their mental health†	86.7	187	87.0	(81.7 – 90.9)	126	86.3	(79.6 – 91.0)	0.85
Who did they suggest ADF member could get help from‡ #								
General practitioner / medical officer	61.0	103	55.1	(47.8 – 62.1)	88	69.8	(61.2 – 77.3)	0.009
Partner	6.1	9	4.8	(2.5 – 9.0)	10	7.9	(4.3 – 14.2)	0.26
Other family member	8.0	13	7.0	(4.1 – 11.7)	12	9.5	(5.4 – 16.1)	0.41
Friend	19.5	42	22.5	(17.0 – 29.1)	19	15.1	(9.8 – 22.6)	0.11
Colleague	8.3	20	10.7	(7.0 – 16.1)	6	4.8	(2.1 – 10.3)	0.06
Supervisor / manager / commander	8.0	19	10.2	(6.5 – 15.4)	6	4.8	(2.1 – 10.3)	0.08
Counsellor / mental health professional	82.4	155	82.9	(76.7 – 87.7)	103	81.7	(73.9 – 87.6)	0.79
Telephone service (e.g. Lifeline, MensLine)	5.1	10	5.3	(2.9 – 9.7)	6	4.8	(2.1 – 10.3)	0.82
Other	4.1	6	3.2	(1.4 – 7.0)	7	5.6	(2.6 – 11.3)	0.31

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Did ADF member seek help after encouragement [†]								0.14
No	18.4	25	15.5	(10.7 – 22.1)	26	22.4	(15.6 – 31.0)	
Yes	81.6	136	84.5	(77.9 – 89.3)	90	77.6	(69.0 – 84.4)	
Missing		26			10			
Did ADF member know where to get help [^]								0.01
No	16.0	14	10.8	(6.4 – 17.5)	20	24.1	(16.0 – 34.7)	
Yes	84.0	116	89.2	(82.5 – 93.6)	63	75.9	(65.3 – 84.0)	
Missing		6			7			
Did family member contact anyone to get help for ADF member [^]	23.0	29	21.3	(15.2 – 29.1)	23	25.6	(17.5 – 35.7)	0.46
Who did they contact for ADF member ⁺ §								
General practitioner / medical officer	25.0	5	17.2	(7.0 – 36.7)	8	34.8	(17.4 – 57.4)	0.15
Other family member	1.9	< 5	3.4	(0.4 – 23.0)	< 5	0.0		1.00 [§]
Friend	15.4	7	24.1	(11.4 – 44.0)	< 5	4.3	(0.5 – 28.4)	0.06 [§]
Colleague	5.8	< 5	3.4	(0.4 – 23.0)	< 5	8.7	(1.9 – 31.4)	0.58 [§]
Supervisor / manager / commander	11.5	5	17.2	(7.0 – 36.7)	< 5	4.3	(0.5 – 28.4)	0.21 [§]
Counsellor / mental health professional	50.0	11	37.9	(21.6 – 57.6)	15	65.2	(42.6 – 82.6)	0.05
Telephone service (e.g. Lifeline, MensLine)	13.5	< 5	10.3	(3.1 – 29.1)	< 5	17.4	(6.2 – 40.3)	0.69 [§]
Other	15.4	6	20.7	(9.1 – 40.4)	< 5	8.7	(1.9 – 31.4)	0.28 [§]

* Only asked of spouses/partners who were concerned about ADF member's mental health (All n = 188; Current n = 305; Ex-serving n = 188).

† Only asked of spouses/partners who ever provided assistance (All n = 362; Current n = 216; Ex-serving n = 146).

‡ Only asked of spouses/partners who encouraged ADF member to get help (All n = 313; Current n = 187; Ex-serving n = 126).

Spouses/partners could select all that applied.

^ Only asked of spouses/partners if ADF member sought help after their encouragement (All n = 226; Current n = 136; Ex-serving n = 90).

+ Only asked of spouses/partners who contacted someone for ADF member (All n = 52; Current n = 29; Ex-serving n = 23).

§ Fisher's exact test.

Note: 95% CI = 95% confidence interval. SE = standard error.

Of the spouses/partners who had concerns about their ADF members' mental health (n = 493), 73.6% had provided assistance at some point, with significant differences evident according to the current or Ex-Serving status of ADF members. Those with Ex-Serving ADF members were more often currently providing help or had done so in the last 12 months (58.0% compared with 45.7% of those with Current Serving ADF members), while those with Current Serving ADF members were more likely to have never provided assistance (28.9% compared with 22.3%) or provided it more than 12 months ago (25.3% compared with 19.7%). There were no significant differences on the types of assistance spouses/partners suggested Current Serving and Ex-Serving ADF

members should access, with the exception that a significantly higher percentage of those with Ex-Serving ADF members had suggested seeking help from a general practitioner/medical officer (69.8% compared with 55.1%).

Of the ADF members whose spouses/partners had encouraged them to seek help (n = 213), 81.6% had done so. There were no significant differences on rates of help seeking between Current Serving and Ex-Serving ADF members, although those who were Current Serving were significantly more often perceived to know where to obtain help (89.2% compared with 75.9% of Ex-Serving ADF members). There were also no significant differences on whether spouses/partners contacted someone to try to obtain help for ADF members, or the type of persons or organisations from whom they had sought help (with the exception of seeking help from a counsellor or mental health professional, which was significantly higher among those with Ex-Serving than Current Serving ADF members – 65.2% compared with 37.9%).

Types of problems leading to help seeking among ADF members – diagnosed mental health conditions

Spouses/partners who had encouraged their ADF members to seek help were asked to provide information on the types of problems exhibited by ADF members that had led to the suggestion that help was needed (n = 313; Table 3.29). The most frequent types of problems were depression (59.1%), anxiety (53.7%), anger (49.8%), sleep (42.8%) and relationship problems (42.2%). (As respondents were able to report multiple mental health problems, the percentages do not add to 100%.) Ex-serving ADF members whose spouses/partners had encouraged them to seek help were significantly more likely than their Current Serving counterparts to be reported as having alcohol or drug problems, nightmares, and pain.

Spouses/partners whose ADF members had sought help following encouragement were then asked whether ADF members had a mental health condition that had been diagnosed by a medical doctor (n = 226). The most common mental health condition was anxiety or stress (46.5%), followed by depression (39.8%) and PTSD (33.6%). The Ex-Serving subgroup significantly more often suffered from depression (53.3% vs. 30.9%), PTSD (47.8% vs. 24.3%) and alcohol abuse/dependency (13.3% vs. 2.2%) than the Current Serving subgroup.

Table 3.29 Mental health problems of ADF members as reported by spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All	Current			Ex-serving			
	%	n	%	(95% CI)	n	%	(95% CI)	
Problems that led family member to encourage ADF member to seek help*								
	(n = 313)	(n = 187)			(n = 126)			
Anger	49.8	88	47.1	(39.9 – 54.3)	68	54.0	(45.1 – 62.6)	0.23
Anxiety	53.7	97	51.9	(44.7 – 59.0)	71	56.3	(47.5 – 64.8)	0.44
Relationship problems	42.2	74	39.6	(32.8 – 46.8)	58	46.0	(37.4 – 54.9)	0.26
Nightmares	23.3	34	18.2	(13.2 – 24.4)	39	31.0	(23.4 – 39.7)	0.009
Depression	59.1	110	58.8	(51.6 – 65.7)	75	59.5	(50.6 – 67.8)	0.90
Alcohol or drug problems	18.5	26	13.9	(9.6 – 19.7)	32	25.4	(18.5 – 33.8)	0.01
Sleep	42.8	80	42.8	(35.8 – 50.0)	54	42.9	(34.4 – 51.7)	0.99
Pain	17.6	22	11.8	(7.8 – 17.3)	33	26.2	(19.2 – 34.7)	0.001
Problems at work	28.7	60	32.1	(25.7 – 39.2)	30	23.8	(17.1 – 32.1)	0.11
Gambling	1.3	< 5	1.6	(0.5 – 4.9)	< 5	0.8	(0.1 – 5.6)	0.65†
Other	16.6	34	18.2	(13.2 – 24.4)	18	14.3	(9.1 – 21.7)	0.36
Mental health condition diagnosed/treated by a medical doctor†								
	(n = 226)	(n = 136)			(n = 90)			
Alcohol abuse or dependency	6.6	< 5	2.2	(0.7 – 6.7)	12	13.3	(7.6 – 22.2)	0.001
Anxiety or stress	46.5	59	43.4	(35.2 – 51.9)	46	51.1	(40.7 – 61.4)	0.25
Depression	39.8	42	30.9	(23.6 – 39.2)	48	53.3	(42.8 – 63.5)	0.0007
PTSD	33.6	33	24.3	(17.7 – 32.3)	43	47.8	(37.5 – 58.2)	0.0002
Other psychiatric/psychological condition needing treatment/counselling	4.9	6	4.4	(2.0 – 9.6)	5	5.6	(2.3 – 12.9)	0.76†

* Only asked of spouses/partners who encouraged ADF members to get help.

† Only asked of spouses/partners if ADF members sought help after their encouragement.

‡ Fisher's exact test.

Note: 95% CI = 95% confidence interval.

3.2.11 Summary

A summary of the findings reported for spouses/partners is next presented. First, general trends across all spouses/partners and their ADF members are presented; followed by significant differences between spouses/partners of Current Serving and Ex-Serving ADF members; and finally, significant differences between Current Serving and Ex-Serving ADF members.

Overall

Spouses'/partners' demographic background

- 3.8% of spouses were aged 18 to 27 years; 28.0% were 28 to 37 years; 35.1% were 38 to 47 years; 27.4% were 48 to 57 years; and 5.7% were aged 58 years or older.
- 91.7% were female.

- A sizeable minority had attained a university degree (47.0%), while 33.9% had attained another type of post-secondary qualification (e.g. a diploma/certificate) and 19.1% had a primary or secondary school qualification.
- 81.2% had one or more children with their ADF members.
- Of those with dependent children, the most common age range of children was 17+ years (28.8%), followed by 10 to 17 years (26.9%), and 4 to 10 years (25.2%).

Living arrangements

- 70.6% of ADF members were living with a spouse/partner and child(ren); and 21.9% were living with a spouse/partner only.
- 89.7% of ADF members were living in the same household with their spouses/partners.
- The most common household size was 4 persons (31.9%), then 2 persons (28.9%) and 3 persons (20.9%).
- 23.5% of spouses/partners had at some stage in their lives not had a permanent place to live in, with this occurring only once for 60.0%.

Employment, income sources, and financial hardships

- 31.2% of spouses/partners were not working at the time of the survey, 41.6% were working full-time, and 27.2% part-time.
- 59.5% had been at their current place of employment for between 2 and 9 years.
- 79.3% of those in employment had taken one or more periods of leave for 6 or more months from their current place of employment.
- Almost equal percentages reported their main income source to be their own paid employment (45.9%) or ADF member's income (44.2%).
- The most common type of financial hardship experienced in the past two years was being unable to pay credit cards or a bank debt on time (24.3%), while 16.1% had been unable to pay gas, electricity or telephone bills on time, and 15.1% had asked for financial help from family or friends.

Residential and school mobility

- Civilian spouses/partners had most commonly lived in 3 to 4 differing places during their ADF member's military service career (30.3%), followed by 5 to 6 places (21.5%).

- Between 22.1 and 24.2% had experienced 1 to 2, 3 to 4 or 7+ residential moves as a result of their ADF members' military service.
- Spouses/partners who were themselves current or former ADF members had most often lived in 3 to 4 different places (24.3%), followed by 0 to 2 different places (20.4%) and 11 or more places (19.7%).
- The most common number of residential moves made because of spouses'/partners' own ADF service was 7+ (25.6%), then 3 to 4 (21.8%) and 5 to 6 (19.5%).
- 37.5% of school-age children had attended four or more schools, while another 19.8% had attended three schools. Around four in ten had attended only one or two schools (42.7%).

Service history

- 17.5% of spouses/partners had themselves been a member of the ADF and 48.0% of these individuals had been deployed.
- 19.9% of all spouses/partners had a parent who had been an ADF member.
- 85.0% of spouses'/partners' ADF members had been deployed, but only 11.8% had been deployed away from their families.
- ADF members had shared their deployment experiences with their spouses/partners 'a little' (39.7%) or 'somewhat' (33.4%), and 23.7% had shared these 'a lot'.

Impact of military service

- The impact of ADF members' military service was seen as having been positive on ADF members' financial situation (74.8%), careers (71.7%), employment (69.5%) and physical health (54.1%). The largest negative effects were in the area of ADF members' mental health (48.3%).
- For civilian spouses/partners, around 40–60% felt there had been no effect on them across the various areas examined, with the only aspect on which a majority felt the effects had been positive being their financial situation (57.1%). The percentage feeling there had been positive effects was especially low on spouses'/partners' employment (15.5%), careers (14.2%) and mental health (14.8%).
- For spouses/partners with a military service background, the effects of their own service were seen as positive across most aspects.

Within-family wellbeing

- 21.4% of spouses/partners reported their couple relationship was unhappy; while 17.5% of ADF members were dissatisfied with their couple relationship.
- 4.8% of spouses/partners had experienced abuse in their couple relationship at some stage.
- Most spouses/partners reported high levels of consistency, warmth and reasoning and low levels of hostility when parenting their children. Most felt they were doing a better-than-average or very good job at parenting their children.
- A similar percentage of children aged 2 to 17 years were in the abnormal range on total behaviour problems to that expected normatively (11.8% compared with 10.0%). Types of behaviour problems with a higher-than-expected incidence were peer problems (17.5%), emotional symptoms (16.9%) and hyperactivity (15.8%), with 10.0% expected normatively. Conversely, a smaller-than-expected percentage showed very low levels of prosocial behaviour (5.3%).

Physical health and quality of life

- 13.7% of spouses/partners reported their general physical health had been poor or very poor in the past 12 months.
- Only 2.2% felt their current quality of life had been poor or very poor.

Lifetime exposure to trauma among spouses/partners

- 50.8% had experienced the unexpected death of someone close to them, 22.3% had witnessed the serious injury or death of another person, while 18.0% had experienced a sexual assault.
- Only 26.3% had not experienced a traumatic event during their lifetime.

Spouses'/partners' involvement in risk-taking

- 10.0% were drinking at problematic levels in the past 12 months.
- 18.5% had used illicit drugs in their lifetime, 2.0% in the past 12 months.
- 28.4% had gambled during the past 12 months, but only 2.7% showed signs of gambling problems.

Spouses'/partners' mental health

- 16.2% had experienced high to very high levels of psychological distress in the past 4 weeks.
- 11.1% had experienced severe PTSD symptoms in the past 4 weeks.

- 13.4% had shown signs of suicidality in the past 12 months (thought about taking their own life, made plans or attempts), but only 1.5% had made a plan or attempted suicide in this time frame.

Concerns about their own mental health, help seeking, barriers, and mental health diagnoses

- 54.4% of all spouses/partners had been concerned about their own mental health during their lifetime.
- 78.2% of those who had been concerned had sought help, although 21.8% had not. Overall, 86.6% of those with concerns knew where to obtain help.
- Of those who did not seek help for their concerns, the most common reasons for not doing so were: they felt they were still functioning effectively (91.7%) and they preferred to manage on their own (79.8%).
- Of spouses/partners with concerns about their own mental health, 43.9% had been diagnosed or treated by a medical doctor for depression, 37.9% for anxiety, and 8.7% for PTSD in their lifetime (note that these figures apply only to the subgroup with concerns, not all spouses/partners).

ADF members' mental health

- 58.7% of spouses/partners had been concerned about their ADF members' mental health at some point, with the average length of time they had held concerns being 6.7 years.
- Of spouses/partners who had been concerned about ADF members' mental health, 73.6% had provided assistance.
- Of the ADF members encouraged to seek professional help, 81.6% did so.
- Of the ADF members who accessed help after encouragement from their spouses/partners, 46.5% were diagnosed or treated by a medical doctor for anxiety or stress, 39.8% for depression, and 33.6% for PTSD (note that these figures apply only to ADF members who had been encouraged to seek help and did so).

Significant differences between spouses/partners of Current Serving and Ex-Serving ADF members

Spouses/partners of Current Serving and Ex-Serving ADF members were compared on the above aspects. Overall, there were **no significant differences** on:

- spouses'/partners' educational background
- sex of spouse

- the percentage who were ex-spouses/ex-partners of ADF members
- whether spouses/partners had dependent children with their ADF members
- the number of times they had been without a permanent place to live, and how recently this had occurred
- their employment characteristics
- children's school mobility
- spouse's/partner's or ADF member's service history
- alcohol use
- levels of physical and mental health.

The **significant differences** found are listed below:

- **Age** – Spouses/partners with Ex-Serving ADF members tended to be older.
- **Household size** – Those with Current Serving ADF members were more likely to be living in a larger sized household.
- **Age of children** – Spouses/partners of Ex-Serving ADF members were more likely to have older children and a higher proportion of their children were living away from home.
- **Residential stability** – Those with Ex-Serving ADF members had been resident in their current home for a longer period of time.
- **Being without a permanent place to live** – A higher percentage of spouses/partners of Ex-Serving ADF members had been without a permanent place to live at some stage of their lives; and this was more likely to have been for 6 months or more when it last occurred. They were also more likely to give travelling or holidaying as a reason for their lack of a permanent residence.
- **Main source of income** – Those with Ex-Serving ADF members were more likely to report their main source of income as being paid employment and less likely as their spouses'/partners' income.
- **Financial hardships** – Those with Ex-Serving ADF members had more often not been able to pay the mortgage or rent on time, needed to pawn or sell something, and a higher percentage had asked for financial help from friends or family or community organisations.
- **Residential mobility** – Civilian spouses/partners of Ex-Serving ADF members had lived in significantly fewer places during their ADF members' military service and

experienced significantly fewer moves as a result of their ADF members' military service than those whose ADF members were Current Serving. Their last move was less likely to be because of a military posting and more likely to be for work, to get a place of their own, or to be near family and friends.

- **Military service history** – A higher percentage of spouses/partners with an Ex-Serving ADF member had a parent who had served in the ADF.
- **Effect of ADF members' military service on civilian spouses/partners** – A significantly higher percentage of those with Current Serving ADF members perceived there to be negative effects on their own employment and career development, while those with Ex-Serving ADF members more often perceived there to be negative effects on their financial situation.
- **Couple relationships** – Those with Ex-Serving ADF members tended to be significantly lower on relationship happiness (although levels were generally high overall). This view was not shared by ADF members, as there were no significant differences on relationship satisfaction by ADF member reports.
- **Abuse in relationships** – While very few reported abuse in couple relationships, rates were significantly higher among spouses/partners of Ex-Serving than Current Serving ADF members.
- **Parenting practices** – Spouses/partners of Current Serving ADF members were likely to be more consistent in their parenting style than those with Ex-Serving ADF members. There were no significant differences on other dimensions of parenting practices or parenting self-efficacy.
- **Child behaviour problems** – Significantly more children with Current Serving than Ex-Serving ADF members had hyperactive behaviour problems in the abnormal range, but there were no significant differences on the other types of child behaviour problems assessed.
- **Exposure to traumatic events** – Those with Ex-Serving ADF members were more likely to have been involved in a life-threatening car accident.
- **Illicit drug use** – While rates were very low overall, those with Ex-Serving ADF members were more likely to have used illicit drugs in the past 12 months.
- **Gambling** – Spouses/partners of Ex-Serving ADF members were more likely to have gambled in the previous 12 months (but did not differ on rates of gambling problems).

- **Suicidality in the past 12 months** – This was significantly higher among spouses/partners of Ex-Serving ADF members, but there were no significant differences on suicide plans or attempts.

Significant differences between Current Serving and Ex-Serving ADF members

The following significant differences between the Current Serving and Ex-Serving ADF members of spouses/partners taking part in the FWS were found (recalling that there were fewer questions about ADF members' wellbeing than about FWS participants):

- **Household type** – Current Serving ADF members were more likely to be living in a household with a spouse/partner and child(ren), and less likely to be in a household with just a spouse/partner.
- **Living away from home** – Current Serving ADF members were more likely to be living away from their families than Ex-Serving ADF members.
- **Effect of military service on ADF members** – Ex-serving ADF members were more often perceived to have experienced negative effects from military service on their employment, financial situation, career, and mental and physical health.
- **Concerns about mental health** – A higher percentage of spouses/partners were concerned about Ex-Serving ADF members' mental health and had first become concerned a longer time ago.
- **Assistance for mental health problems** – Spouses/partners of Ex-Serving ADF members were more likely to have provided assistance for mental health problems. A higher percentage of Current Serving ADF members knew where to obtain professional help (although there were no significant differences on the uptake of professional help).
- **Rates of diagnosed mental health conditions among ADF members who were encouraged by spouses/partners to seek help and did so** – This subset of Ex-Serving ADF members had higher rates of depression, PTSD and alcohol abuse/dependency (noting that these findings apply to only a subset of ADF members, not all ADF members).

3.3 How were the adult children of ADF members faring?

This section reports how the adult children of Current Serving and Ex-Serving ADF members were faring. We first describe how all adult children were progressing, and then compare the adult children of Current Serving and Ex-Serving ADF members. Six broad areas are examined:

1. demographic and background characteristics (e.g. age, sex, education)
2. adult children's military service; perceptions of the effect of ADF members' military service on ADF members and on adult children
3. involvement in risk-taking
4. physical and mental health
5. concerns about their own mental health
6. concerns about their ADF members' mental health.

3.3.1 Method

Sample

This section uses the adult children dataset 'Sample 6: Adult children data' (see Chapter 2 for details). The sample comprises 102 adult children who had complete demographic data and had completed at least half of the survey. Fifty-four were the children of Current Serving ADF members (52.9%) and 48 were the children of Ex-Serving ADF members (47.1%). As the sample of adult children is small, there is reduced power to detect statistically significant differences, resulting in only being able to detect large differences.

Statistical analyses

Summary statistics are provided for all adult children and stratified by the serving status of ADF members (Current Serving or Ex-Serving). For categorical measures, percentages are calculated, with the difference between spouses/partners of Current Serving and Ex-Serving ADF members tested using the chi-square test or Fisher's exact test. The latter test was used if an expected cell count was fewer than five people. For continuous measures, the mean and standard deviation were calculated and differences tested using *t*-tests. All tests were two-sided and *p*-values are included in the tables so that the strength of the evidence of a statistically significant difference between the two groups can be assessed. We have interpreted *p*-values of ≤ 0.05 as providing sufficient evidence of a difference.

3.3.2 Adult children's personal characteristics and military service

Around two in three adult children were aged 18 to 27 years (68.6%), while almost all remaining adult children were 28 to 37 years of age. Those whose ADF members were Current Serving tended to be significantly younger than those whose ADF members were Ex-Serving (Table 3.30). Around three in four adult children respondents were female (73.5%). Respondents had most frequently achieved a primary or secondary school qualification (43.1%), followed by a university degree (31.4%) or certificate/diploma (25.5%). These figures may be affected by some adult children not yet having completed their educational careers. No significant differences were found on sex or the highest level of education achieved when comparing the adult children of Current Serving and Ex-Serving ADF members.

Most adult children respondents had not been involved in military service, with only 10.8% being current or former serving ADF members themselves. There was no significant difference on the frequency of ADF service when the adult children of Current Serving and Ex-Serving ADF members were compared.

Table 3.30 Adult children's personal characteristics and military service, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Age (years)								0.01
18 – < 28	68.6	44	81.5	(68.4 – 89.9)	26	54.2	(39.6 – 68.0)	
28 – < 38	30.4	10	18.5	(10.1 – 31.6)	21	43.8	(30.1 – 58.4)	
38 – < 48	1.0				< 5	2.1	(0.3 – 14.2)	
Sex								0.89
Female	73.5	40	74.1	(60.4 – 84.3)	35	72.9	(58.2 – 83.9)	
Male	26.5	14	25.9	(15.7 – 39.6)	13	27.1	(16.1 – 41.8)	
Highest level of education								0.17
Primary/secondary school	43.1	28	51.9	(38.3 – 65.1)	16	33.3	(21.2 – 48.2)	
Certificate/diploma	25.5	12	22.2	(12.8 – 35.7)	14	29.2	(17.8 – 44.0)	
University degree	31.4	14	25.9	(15.7 – 39.6)	18	37.5	(24.7 – 52.4)	
Current or Ex-serving ADF member								0.45
No	89.2	47	87.0	(74.7 – 93.8)	44	91.7	(79.2 – 97.0)	
Yes	10.8	7	13.0	(6.2 – 25.3)	< 5	8.3	(3.0 – 20.8)	

Note: 95% CI = 95% confidence interval.

Impact of ADF member's military service on ADF members and their adult children

Around one in three adult children thought that military service had had a positive influence on their ADF parent's couple relationship (38.4%), relationships with other immediate family (32.9%), wider family (33.3%), and mental health (33.3%). Three in five thought it had a positive effect on their ADF parent's relationship with friends (60.5%) and physical health (60.2%). It was also perceived to have a positive effect on their ADF parent's employment (70.2%), financial situation (78.7%) and career (79.2%).

Statistical evidence of significant differences between the adult children of Current Serving and Ex-Serving ADF members was found only for couple relationships, and physical and mental health, all reflecting more positive effects for Current Serving ADF parents compared to Ex-Serving ADF parents (Figure 3.7; see Appendix E for details).

Many civilian adult children felt they personally had been unaffected by their parents' military service, especially in the areas of physical health (71.1%), career (66.7%), employment (65.5%), financial situation (62.2%), mental health (53.0%) and relationships with their wider family (50.6%). The largest positive effect was found on adult children's relationship with other immediate family members (39.3%), while the largest negative effect was on their mental health (33.7%). The only significant difference between those with Current Serving and Ex-Serving ADF parents was on relationships with friends, with a higher percentage of adult children of Ex-Serving ADF members reporting no influence (55.8% Ex-Serving compared with 29.3% with Current Serving; see Figure 3.8 and Appendix E).

Figure 3.7 Perceived effect of ADF members’ service on ADF members (adult children perspectives), stratified by military status of ADF member

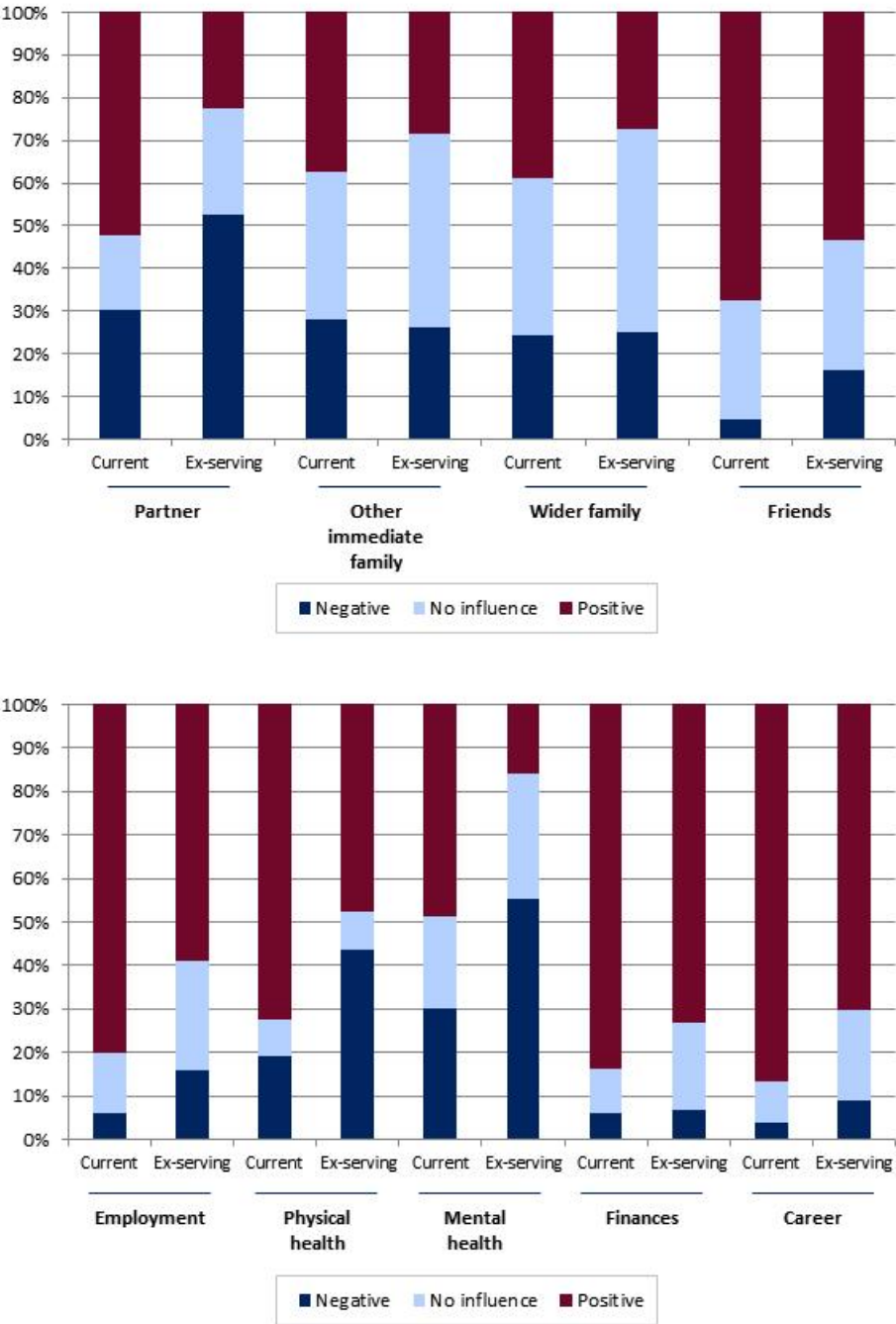
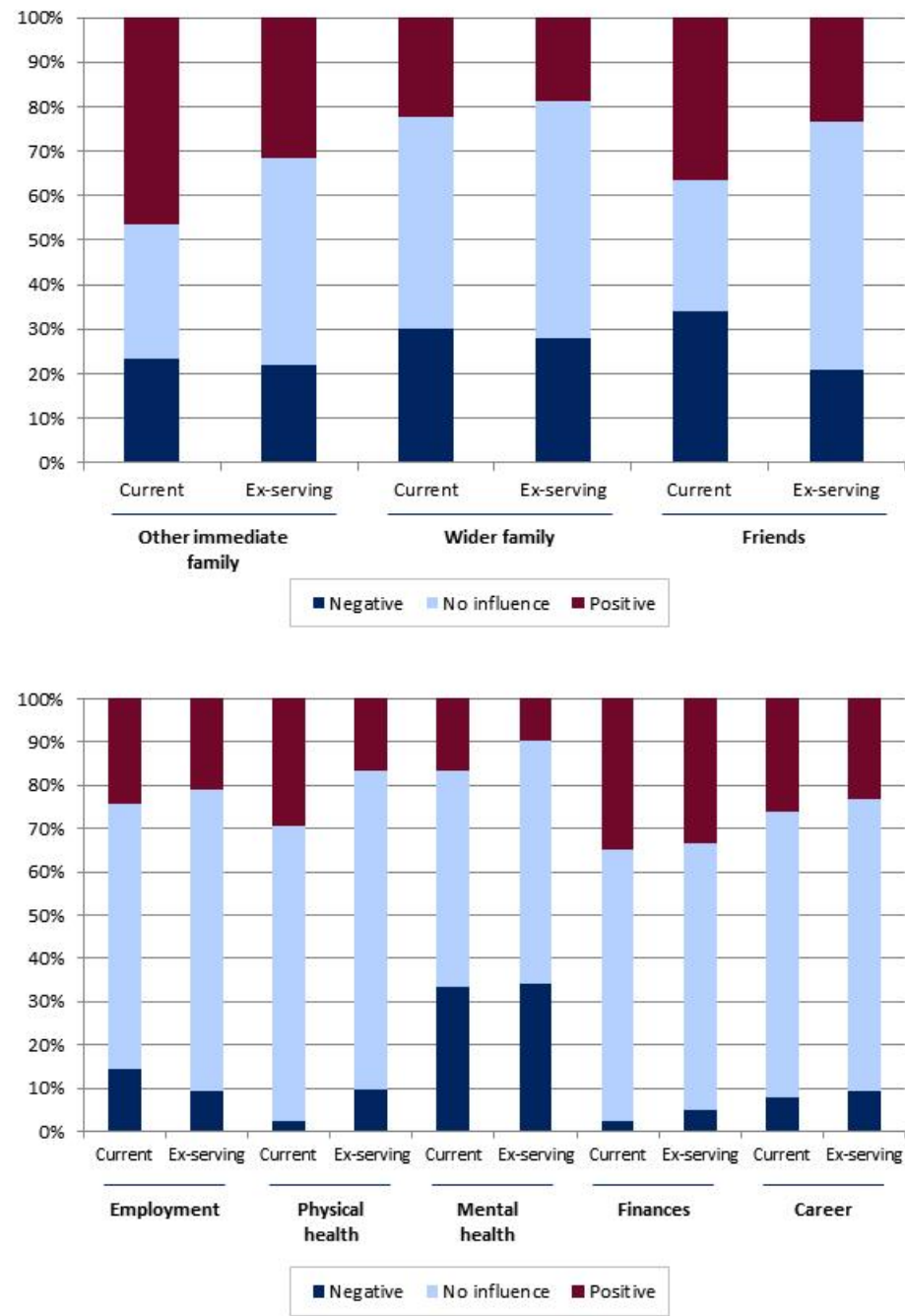


Figure 3.8 Perceived effect of ADF members’ service on their adult children, stratified by military status of ADF member



3.3.3 Adult children's health

Physical health and quality of life

Adult children were asked to rate how their general physical health had been over the past 12 months (Table 3.31). Less than one in ten adult children reported their health had been poor or very poor in the past 12 months (8.8%), with this not significantly differing between the adult children of Current Serving and Ex-Serving ADF members. Adult children were also asked to rate their current quality of life, with very few feeling their quality of life had been poor (2.0%). Again, there were no significant differences according to the ADF status of ADF members.

Table 3.31 Adult children's physical health and quality of life, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Poor physical health	8.8	5	9.3	(3.8 – 20.9)	< 5	8.3	(3.0 – 20.8)	1.00*
Poor quality of life	2.0	< 5	1.9	(0.2 – 12.7)	< 5	2.1	(0.3 – 14.2)	1.00*

* Fisher's exact test.

Note: 95% CI = 95% confidence interval.

Risk-taking

A series of questions from the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993; see Chapter 2 for details) examined the frequency of alcohol use, symptoms of dependence, and respondents' experience of problems arising from alcohol use. The criterion of an AUDIT score of 8 or higher was used to identify problem drinking. Illicit drug use was assessed by questions asking whether respondents had used illicit drugs in their lifetime and in the past 12 months. An answer of 'yes' to any of the listed illicit drugs was used to classify adult children as having used illicit drugs. The Problem Gambling Severity Index (Volberg & Williams, 2012; Miller et al., 2013; see Chapter 2) was used to assess engagement in gambling and experience of problems when gambling. The normative cut-off provided by the scale was used to identify those showing signs of problem gambling.

Just under one in five adult children reported levels of drinking that were categorised as problematic (18.6%), 40.9% had used illicit drugs in their lifetime, and 16.1% in the last 12 months. A total of 44.1% had gambled in the previous 12 months and 9.8% had shown signs of problem gambling (Table 3.32). There was no statistical evidence of differences between the adult children of Current Serving and Ex-Serving ADF members on these aspects.

Table 3.32 Adult children's involvement in risk-taking, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Problem drinking								
Score (mean, SE)	0.44	4.98	0.67	(3.64 – 6.32)	5.17	0.55	(4.06 – 6.27)	0.83
Problem drinker	18.6	10	18.5	(10.1 – 31.6)	9	18.8	(9.8 – 32.9)	0.98
Illicit drug use: ever	40.9	17	31.5	(20.2 – 45.4)	23	47.9	(33.8 – 62.3)	0.09
Illicit drug use: last 12 months*	16.1	6	11.1	(4.9 – 23.1)	9	19.1	(10.0 – 33.5)	0.26
Gambled in last 12 months*	44.1	21	38.9	(26.6 – 52.8)	24	50.0	(35.7 – 64.3)	0.26
Problem gambling								
Score (mean, SE)	0.12	0.35	0.22	(-0.09 – 0.80)	0.19	0.08	(0.03 – 0.34)	0.51
Problem gambling	9.8	< 5	7.4	(2.7 – 18.6)	6	12.5	(5.6 – 25.8)	0.39

* Analyses conducted on adult children who are not currently serving in the ADF (All n = 93; Current n = 49; Ex-serving n = 44).
Note: 95% CI = 95% confidence interval. SE = standard error.

Mental health problems

Psychological distress among adult children was measured using the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002; see Chapter 2 for details). The norms provided were used to identify those experiencing 'high' to 'very high' levels of psychological distress. Symptoms of PTSD were assessed using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers et al., 1993; see Chapter 2). Respondents who had experienced one or more traumatic events in their lifetime were asked how much they had been bothered by PTSD symptoms in the past month, with the cut-off provided used to identify those with high levels of PTSD symptoms. Suicidal ideation and behaviours over the past 12 months was used to identify adult children showing signs of suicidality (had thought of taking their own life, had made plans or attempts).

A total of 29.0% of responding adult children had experienced moderate to very high psychological distress in the past four weeks (Table 3.33), 12.0% reported high levels of PTSD symptoms, 18.0% had shown signs of suicidality in the past 12 months, and 4.0% had made a plan or tried to commit suicide in this time frame. There was no statistical evidence of significant differences in rates of mental health problems between those with Current Serving and Ex-Serving ADF members.

Table 3.33 Adult children's mental health, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Psychological distress								
Score (mean, SE)	0.9	18.63	1.21	(16.21 – 21.05)	18.84	1.34	(16.15 – 21.53)	0.91
High/very high	29.0	13	24.1	(14.3 – 37.7)	16	34.8	(22.1 – 50.0)	0.24
PTSD	12.0	8	14.8	(7.4 – 27.4)	< 5	8.7	(3.2 – 21.7)	0.54
Suicidality	18.0	11	20.4	(11.4 – 33.6)	7	15.2	(7.2 – 29.3)	0.61*
Made a plan or attempted suicide	4.0	< 5	3.7	(0.9 – 14.2)	< 5	4.3	(1.0 – 16.5)	1.00*

* Fisher's exact test.

Note: 95% CI = 95% confidence interval. SE = standard error.

Over all adult children, 57.0% had been concerned about their own mental health at some stage, with the average length of time since they had first become concerned being 7.2 years (Table 3.34). There was no evidence of significant differences between the adult children of Current Serving and Ex-Serving ADF members on whether they had concerns about their own mental health and when they first started becoming concerned.

Table 3.34 Adult children's concerns about their own mental health, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned own mental health	57.0	30	55.6	(41.8 – 68.5)	27	58.7	(43.6 – 72.3)	0.75
Number of years since first became concerned about own mental health*								
Number of years (mean, SE)	0.8	7.0	1.1	(4.7 – 9.3)	7.4	1.2	(4.9 – 9.9)	0.82

* Only asked of those with concerns.

Note: 95% CI = 95% confidence interval. SE = standard error.

3.3.4 Concerns about ADF members' mental health

Overall, 42.0% of adult children had been concerned about their ADF parents' mental health at some time, and these concerns had first commenced on average 6.7 years ago (Table 3.35). A significantly higher percentage of adult children of Ex-Serving ADF members had concerns compared to the adult children of Current Serving ADF members. However, there was no evidence of a significant difference on when they first become concerned.

Table 3.35 Concerns about ADF members' mental health (adult child perspectives), stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned about ADF member's mental health	42.0	18	33.3	(21.8 – 47.3)	24	52.2	(37.4 – 66.6)	0.06
Number of years since first became concerned about ADF member's mental health*								
Number of years (mean, SE)	0.9	5.4	1.0	(3.3 – 7.5)	7.7	1.3	(5.0 – 10.4)	0.19

* Only asked of those with concerns.

Note: 95% CI = 95% confidence interval. SE = standard error.

3.3.5 Summary

A summary of the findings relating to the adult children of Ex-Serving and Current Serving ADF members is next presented. First, an overview of findings for all adult children is provided, followed by a description of the aspects on which the adult children of Ex-Serving and Current Serving ADF parents were found to differ. Finally, differences between the Ex-Serving and Current Serving ADF parents of responding adult children are described.

Overall

Demographics

- 68.6% of adult children were 18 to 27 years old and 30.4% were 28 to 37 years.
- 73.5% were female.
- 43.1% reported their highest level of education to be primary or secondary school.
- 31.4% had attained a university degree, and 25.5% a certificate/diploma.

Service history

- 10.8% of adult children had been, or were currently, ADF members.

Impact of military service

- Around one in three adult children felt the impact of military service on their ADF parents had been positive on their relationship with spouses/partners (38.4%), other immediate (32.9%) and wider family (33.3%), and mental health (33.3%). Three in five thought it had been a positive influence on their ADF parents' relationship with friends (60.5%) and physical health (60.2%). Around seven in ten thought it had been positive on their employment (70.2%), financial situation (78.7%) and careers (79.2%).

- A majority of adult children felt that their ADF parents' military service had not had an effect on their own career (66.7%), employment (65.5%), financial situation (62.2%) and physical health (71.1%). The largest negative effect reported was on adult children's mental health (33.7%).

Physical health and quality of life

- 8.8% of adult children rated their general physical health as being poor or very poor in the past 12 months.
- Only 2.0% felt their current quality of life had been poor or very poor.

Involvement in risk-taking

- 18.6% reported drinking at problem levels in the past 12 months.
- 40.9% had used illicit drugs in their lifetime, 16.1% in the past 12 months.
- 44.1% had gambled during the past 12 months, 9.8% at problematic levels.

Mental health

- 29.0% reported high to very high levels of psychological distress in the past 4 weeks.
- 12.0% reported experiencing high levels of PTSD symptoms recently.
- 18.0% reported suicidality in the past 12 months (thought about taking their own life, made plans or attempts) and 4.0% had made a plan or attempted suicide in this time frame.

Concerns about their own mental health, help seeking

- 57.0% had been concerned about their own mental health during their lifetime, with the average length of time they had held concerns being 7.2 years.

Concerns about ADF members' mental health

- 42.0% had been concerned about their ADF members' mental health at some point, on average for 6.7 years.

Significant differences between the adult children of Ex-Serving and Current Serving ADF members

There were only two statistically significant differences between the adult children of Current Serving and Ex-Serving ADF members:

- the adult children of Current Serving ADF members tended to be younger than the children of Ex-Serving ADF members

- children of Ex-Serving ADF parents more often reported there had been no effect of their ADF parents' military service on adult children's friendships compared to those with Current Serving ADF parents.

We found no statistical evidence of significant differences between the two groups on respondent's sex; educational background; whether they had, or were currently, serving in the ADF; the influence of the ADF members' military service on them (with the exception of friendships); involvement in risk-taking; current quality of life, physical and mental health; and rates of concern about their own mental health over their lifetime or how long they had been concerned.

Significant differences between Ex-Serving and Current Serving ADF members according to their adult children

Adult children of Current Serving ADF members were more likely to perceive there had been positive effects of military service on ADF members' couple relationships, and physical and mental health than the adult children of Ex-Serving ADF members. A higher percentage of children of Ex-Serving ADF members had concerns about their ADF parents' mental health, but did not significantly differ on when they first became concerned.

3.4 How were the parents of ADF members faring?

This section reports on the wellbeing of parents of Current Serving and Ex-Serving ADF members. The responses of parents are first described overall, then compared by the military status of their ADF members. The areas covered are:

1. parents' personal characteristics (e.g. age, sex, education)
2. family military service history (e.g. whether parents served in the ADF, perceptions of the impact of ADF members' military service on themselves and on parents)
3. parents' health (e.g. physical health, risk-taking behaviours, mental health problems, help seeking, assistance for mental health problems)
4. concerns about their ADF sons'/daughters' mental health (e.g. whether parents had been concerned about their mental health, whether parents provided assistance for their mental health problems).

3.4.1 Method

Sample

This section uses the parent dataset ‘Sample 5: Parents data’ (see Chapter 2). The sample comprises 275 parents who had complete demographic data and had completed at least half of the survey. A total of 182 were the parents of Current Serving ADF members (66.2%) and 93 were parents of Ex-Serving ADF members (33.8%).

Statistical analysis

Summary statistics are provided for all parents of ADF members and stratified by whether their ADF sons/daughters were Current Serving or Ex-Serving. For categorical measures, percentages are calculated, and differences between Current Serving and Ex-Serving ADF members are tested using the chi-square test or Fisher’s exact test. The latter test was used if an expected cell count was fewer than five. For continuous measures, the means and standard deviation were calculated and differences tested using *t*-tests. All tests were two-sided and *p*-values are included in the tables so that the strength of the evidence of a statistically significant difference between the two groups can be assessed. We have interpreted *p*-values of ≤ 0.05 as providing sufficient evidence of a difference.

3.4.2 Parents’ personal characteristics and military experience

As might be expected, 70.9% of FWS parents were aged 58 or older, with almost all other FWS parents being 48 to 57 years of age (28.0%). No significant difference was detected on the age of parents of Current Serving and Ex-Serving ADF members (Table 3.36). Around two in three parents were female (68.7%), with the percentage of females being significantly higher among parents of Ex-Serving ADF members (80.6% compared with 62.6%). The highest level of education achieved by responding parents was most commonly a certificate or diploma (38.5%), followed by a university degree (33.1%), then primary or secondary education (28.4%). Parents of Ex-Serving or Current Serving ADF members did not significantly differ on their highest level of education.

A total of 15.6% of all parents had themselves been ADF members, with rates similar across Ex-Serving and Current Serving ADF member subgroups. Just over one in three of FWS parents’ own parents (i.e. ADF members’ grandparents) had served in the ADF (37.1%), with this not significantly differing across Current Serving and Ex-Serving subgroups.

Table 3.36 Parents' personal characteristics and military service, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Age (years)								0.86
38 – < 48	1.1	< 5	1.1	(0.3 – 4.3)	< 5	1.1	(0.1 – 7.5)	
48 – < 58	28.0	49	26.9	(20.9 – 33.9)	28	30.1	(21.5 – 40.4)	
58+	70.9	131	72.0	(64.9 – 78.1)	64	68.8	(58.5 – 77.5)	
Sex								0.002
Female	68.7	114	62.6	(55.3 – 69.4)	75	80.6	(71.2 – 87.6)	
Male	31.3	68	37.4	(30.6 – 44.7)	18	19.4	(12.4 – 28.8)	
Highest level of education								0.57
Primary/secondary school	28.4	48	26.4	(20.4 – 33.3)	30	32.3	(23.4 – 42.6)	
Certificate/diploma	38.5	73	40.1	(33.2 – 47.5)	33	35.5	(26.3 – 45.9)	
University degree	33.1	61	33.5	(27.0 – 40.8)	30	32.3	(23.4 – 42.6)	
Current or Ex-Serving ADF member								0.85
No	84.4	153	84.1	(77.9 – 88.7)	79	84.9	(76.0 – 91.0)	
Yes	15.6	29	15.9	(11.3 – 22.1)	14	15.1	(9.0 – 24.0)	
One or more parents were in the ADF								0.83
No	62.9	113	62.4	(55.1 – 69.2)	58	63.7	(53.2 – 73.1)	
Yes	37.1	68	37.6	(30.8 – 44.9)	33	36.3	(26.9 – 46.8)	

Note: 95% CI = 95% confidence interval.

3.4.3 Effects of military service

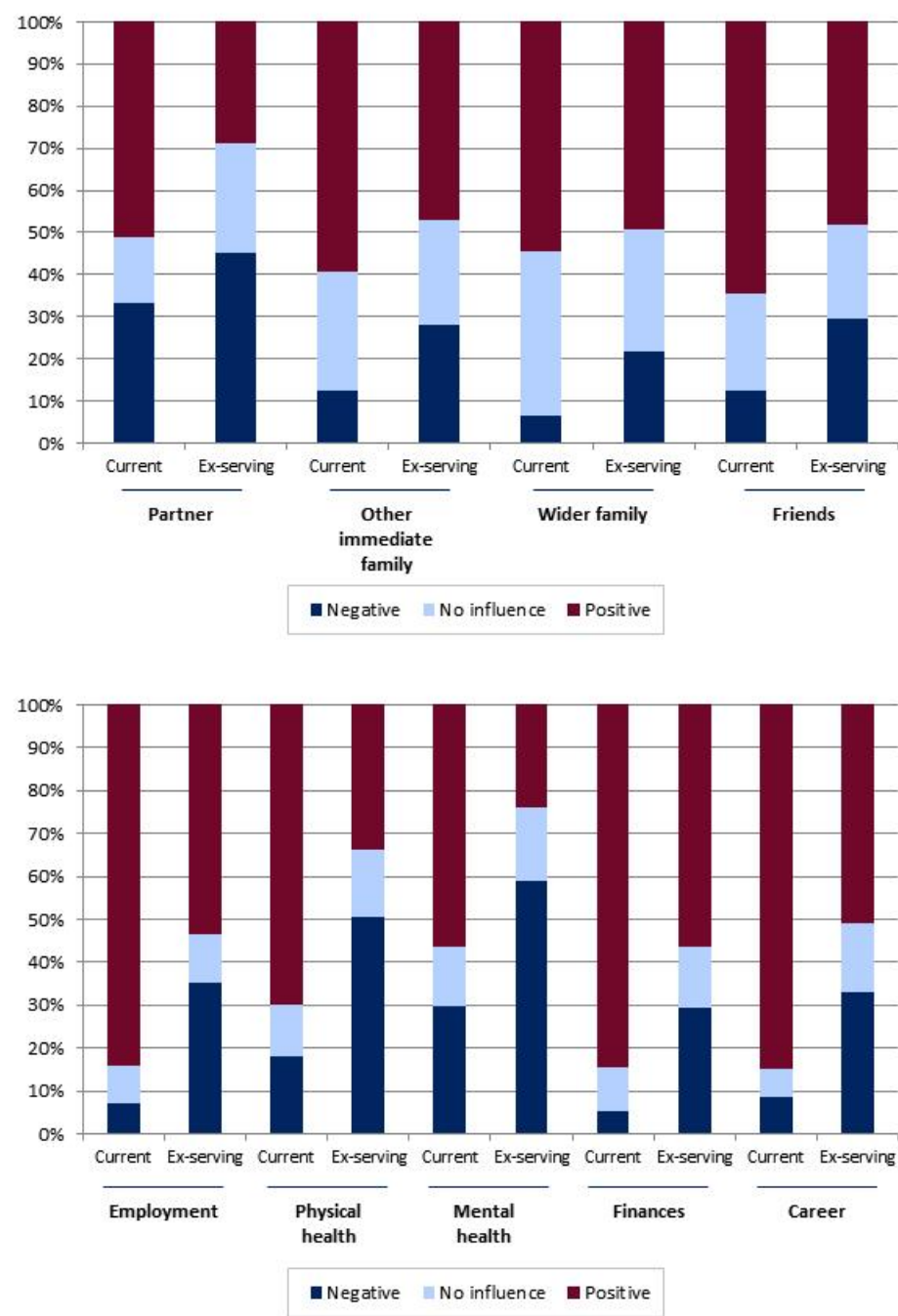
The impact of military service on ADF members and responding parents

Overall, around three in four responding parents perceived there to have been a positive effect of military service on their ADF sons'/daughters' financial situation (75.2%), careers (73.6%) and employment (73.0%) (see Appendix F for details). Just over half thought it had a positive influence on their ADF members' other relationships: immediate family members (55.1%), wider family (52.8%) and friends (59.1%), while 57.5% thought that it had a positive influence on their physical health and 45.2% on their mental health. Similarly, 44.1% thought that it had a positive influence on their ADF sons'/daughters' relationships with spouses/partners.

We next look at whether parents' perceptions of the influence of military service on ADF members differed across Current Serving or Ex-Serving subgroups, as shown in Figure 3.9 and Appendix F. Parents of Ex-Serving ADF members were more likely to see military service as having a less positive or more negative impact than parents whose sons/daughters were Current Serving. While around half the parents of Current Serving ADF members thought military service had a positive effect on their ADF

sons'/daughters' couple relationships (51.1%), only 29.0% of parents of Ex-Serving ADF members had similar perceptions. Likewise, a higher percentage of parents of Ex-Serving ADF members thought there had been negative effects on ADF members' relationships with other immediate family members (28.1% compared with 12.6% of parents of Current Serving sons/daughters), wider family (21.7% compared with 6.7%), and friends (29.6% compared with 12.4%).

Figure 3.9 Parent perceptions of the effect of ADF members’ service on ADF members, stratified by military status of ADF member

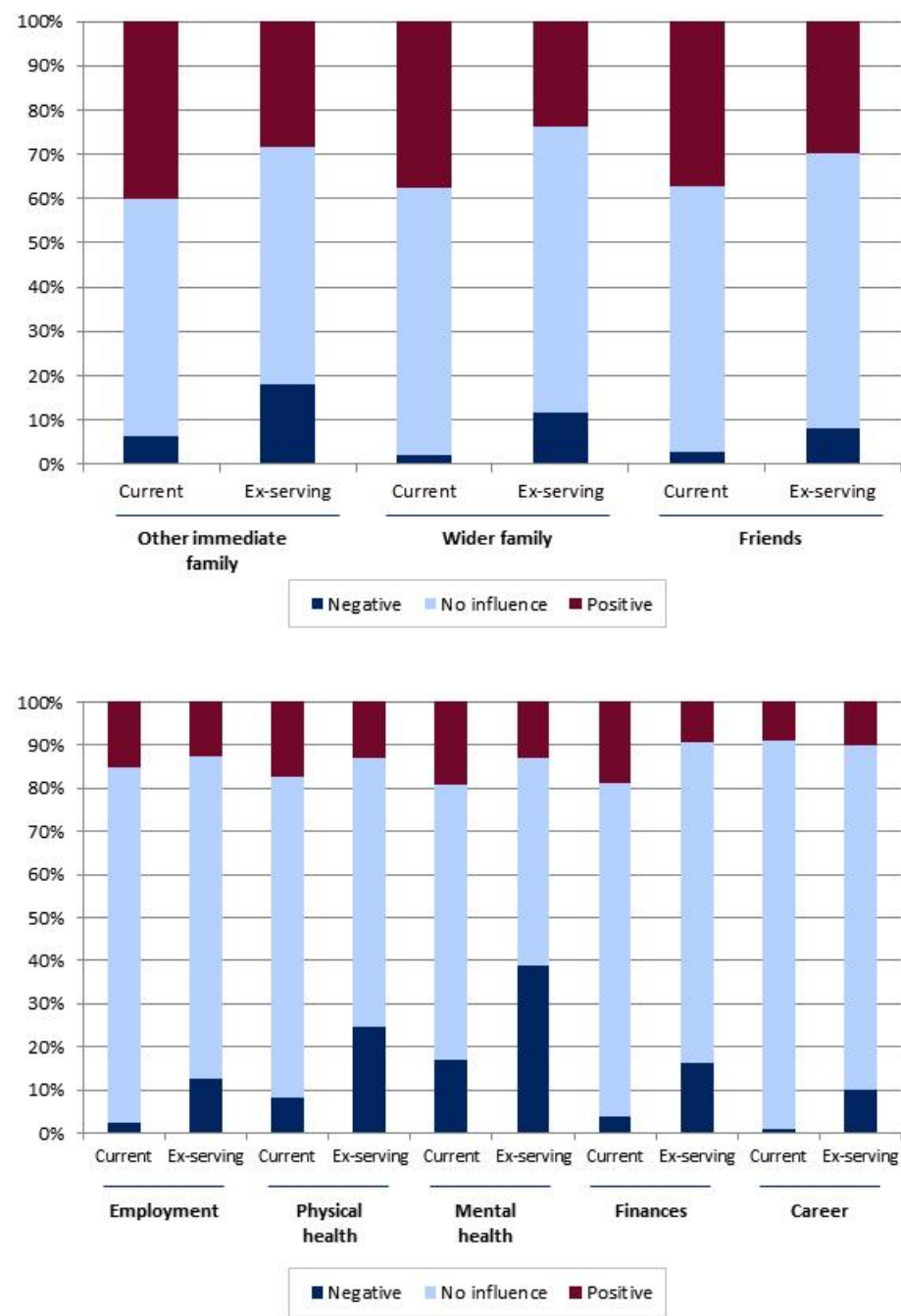


There were also large differences between parents of Ex-Serving and Current Serving ADF members in their perceptions of the effects on physical and mental health, with 50.6% of parents of Ex-Serving compared to 18.2% of parents of Current Serving believing military service had a negative influence on their ADF sons'/daughters' physical health, whereas 33.7% of Ex-Serving compared to 70.0% of Current Serving thought it had a positive effect. Twice as many parents of Ex-Serving than Current Serving ADF members thought there had been negative effects on their sons'/daughters' mental health (59.0% compared to 29.7%). Likewise, around three in four parents of Current Serving ADF members compared with about half of parents of Ex-Serving ADF members thought that military service had a positive effect on their ADF sons'/daughters' employment, financial situation and career.

Parents were also asked about the effect of their ADF sons'/daughters' military service on their own wellbeing. Across all areas, a majority felt there had been no effects on parents (between 53.8% and 86.6%; see Appendix F for details). Thus, 53.8% reported that military service had no effect on parents' immediate family relationships, 61.8% on their wider family relationships, 60.6% on their friendships, 70.0% on parents' physical health, 58.1% on their mental health, 79.6% on their employment, 76.2% on their financial situation, and 86.6% on their careers.

When parents of Current Serving and Ex-Serving ADF members were compared on their perceptions of the effects of military service, significant differences were found on all aspects except relationship with friends, as shown in Figure 3.10 (see Appendix F for details). These mainly reflected the higher percentage of parents of Ex-Serving sons/daughters reporting there had been a negative effect. This was seen for parents' own relationships with their immediate family (17.9% of parents of Ex-Serving compared with 6.3% of parents of Current Serving), physical health (24.7% compared with 8.3%), mental health (39.0% compared with 17.1%), employment (12.5% vs. 2.4%), financial situation (16.2% vs. 3.9%) and career (9.9% vs. 0.8%).

Figure 3.10 Perceived effect of ADF members' service on parents, stratified by military status of ADF member



3.4.4 Parents' health

Physical health and quality of life

Parents were asked to rate how their general physical health had been over the past 12 months using the response categories of 'excellent', 'very good', 'fair', 'poor' and 'very poor'. Those who had responded 'poor' or 'very poor' were considered to have poor health. Only 8.4% of parents reported having poor health, with no significant difference between parents of Current Serving and Ex-Serving ADF members evident (Table 3.37). They also rated their current quality of life, with very few feeling this was poor (2.9%). Again, this did not significantly differ across parents of Current Serving and Ex-Serving ADF members.

Table 3.37 Parents' physical health and quality of life, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Poor physical health	8.4	15	8.2	(5.0 – 13.3)	8	8.6	(4.3 – 16.5)	0.92
Poor quality of life	2.9	5	2.7	(1.1 – 6.5)	< 5	3.2	(1.0 – 9.7)	1.00*

* Fisher's exact test.

Note: 95% CI = 95% confidence interval.

Risky behaviours

A series of questions from the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993; see Chapter 2 for details) was used to measure parents' frequency of alcohol use, symptoms of dependence, and problems arising from alcohol use. The criterion of an AUDIT score of 8 or higher was used to identify problem drinking. Illicit drug use was assessed by questions asking whether parents had used illicit drugs in their lifetime and in the past 12 months, with those answering 'yes' classified as having engaged in illicit drug use. The Problem Gambling Severity Index (Volberg & Williams, 2012; Miller et al., 2013; see Chapter 2) was used to assess engagement in gambling and experience of problems when gambling. The cut-off provided was used to identify parents showing signs of problem gambling.

As shown in Table 3.38, fewer than one in ten of all parents had been involved in risky drinking in the last 12 months (8.1%), had ever taken illicit drugs (8.7%), or had taken illicit drugs in last 12 months (1.4%). Around one in three had gambled in the last 12 months (31.4%), and 4.7% showed signs of gambling problems. There were no significant differences between parents of Current Serving and Ex-Serving ADF members on engagement in these various types of risk-taking (Table 3.38).

Table 3.38 Parents' involvement in risk-taking, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Problem drinking								
Score (mean, SE)	0.2	3.53	0.21	(3.11 – 3.95)	3.02	0.38	(2.28 – 3.77)	0.21
Problem drinker	8.1	15	8.3	(5.0 – 13.3)	7	7.6	(3.6 – 15.3)	0.85
Illicit drug use: ever*	8.7	15	8.2	(5.0 – 13.3)	9	9.7	(5.1 – 17.8)	0.69
Illicit drug use: last 12 months*	1.4	< 5	1.6	(0.5 – 5.0)	< 5	1.1	(0.1 – 7.5)	1.00†
Gambled in last 12 months	31.4	56	30.8	(24.4 – 37.9)	30	32.6	(23.7 – 43.0)	0.76
Problem gambling								
Score (mean, SE)	0.08	0.26	0.10	(0.06 – 0.47)	0.13	0.09	(–0.05 – 0.31)	0.40
Problem gambling	4.7	11	6.0	(3.4 – 10.6)	< 5	2.2	(0.5 – 8.5)	0.15

* Because illicit drug use is prohibited among serving ADF members and leads to instant dismissal, data for Current Serving parents were not included in analyses of illicit drug use. Analyses of illicit drug use are based on a reduced sample of parents.

† Fisher's exact test.

Note: 95% CI = 95% confidence interval. SE = standard error.

Mental health problems

Psychological distress was measured using the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002; see Chapter 2 for details). The K10 provides norms by which to identify those experiencing 'high' to 'very high' levels of psychological distress. Symptoms of PTSD were assessed using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers et al., 1993; see Chapter 2). Respondents who had experienced one or more traumatic events in their lifetime were asked how much they had been bothered by symptoms of PTSD in the past month. The cut-off provided was used to identify those with high levels of PTSD symptoms. Suicidal ideation and behaviour in the past 12 months was assessed via four items. Those who answered 'yes' to any of four items were classified as showing signs of suicidality.

Over all parents, 14.4% were categorised as experiencing moderate to very high levels of psychological distress in the past four weeks, 11.9% reported recent high levels of PTSD symptoms, 10.6% of all parents had shown signs of suicidality during the previous 12 months, while 2.6% had made a plan or attempted suicide (Table 3.39). We found no statistical evidence of significant differences between parents of Current Serving and Ex-Serving ADF members on any mental health measures.

Table 3.39 Parents' mental health, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Psychological distress								
Score (mean, SE)	0.38	15.00	0.50	(14.02 – 15.98)	15.07	0.60	(13.89 – 16.25)	0.94
High/very high	14.4	28	15.7	(11.0 – 21.9)	11	11.8	(6.6 – 20.3)	0.38
PTSD	11.9	17	9.6	(6.0 – 14.9)	15	16.5	(10.1 – 25.8)	0.10
Suicidality	10.6	18	10.5	(6.7 – 16.1)	10	10.8	(5.8 – 19.0)	0.94
Made a plan or attempted suicide	2.6	5	2.9	(1.2 – 6.8)	< 5	2.2	(0.5 – 8.4)	1.00*

* Fisher's exact test.

Note: 95% CI = 95% confidence interval. SE = standard error.

Two out of five parents had been concerned about their own mental health at some stage of their lives (40.1%), with 57.5% first being concerned 10 or more years ago (Table 3.40). The average length of time since they had first been concerned was 15.5 years. Most of those with concerns had sought help (81.3%), with 47.7% of those with concerns seeking help within three months of becoming concerned, 16.8% within a year and 16.8% after a year. Around one in three had sought help recently (21.5% currently and 8.4% within the previous 12 months). Almost all (89.7%) knew where to obtain help. There was no evidence of significant differences between parents of Current Serving and Ex-Serving ADF members on their frequency of concerns about their own mental health, or help-seeking behaviour.

Table 3.40 Parents' concerns about their own mental health, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned about own mental health	40.1	72	41.4	(34.2 – 48.9)	35	37.6	(28.2 – 48.1)	0.55
Number of years since first became concerned about own mental health*								
Number of years (mean, SE)	1.2	16.1	1.4	(13.2 – 18.9)	14.1	2.0	(10.0 – 18.2)	0.42
Number of years								0.81
≤1 year	7.5	5	6.9	(2.9 – 15.9)	< 5	8.8	(2.7 – 25.2)	
2 years	3.8	< 5	2.8	(0.7 – 10.8)	< 5	5.9	(1.4 – 22.0)	
3 years	5.7	< 5	5.6	(2.1 – 14.2)	< 5	5.9	(1.4 – 22.0)	
4 years	10.4	6	8.3	(3.7 – 17.6)	5	14.7	(6.0 – 31.9)	
5–9 years	15.1	11	15.3	(8.5 – 25.8)	5	14.7	(6.0 – 31.9)	
10–19 years	22.6	19	26.4	(17.3 – 38.0)	5	14.7	(6.0 – 31.9)	
20+ years	34.9	25	34.7	(24.4 – 46.6)	12	35.3	(20.6 – 53.4)	
First sought help for own mental health problems*								0.22
Within 3 months of becoming concerned	47.7	37	51.4	(39.7 – 62.9)	14	40.0	(24.7 – 57.6)	
Within 1 year of becoming concerned	16.8	14	19.4	(11.7 – 30.5)	< 5	11.4	(4.1 – 27.8)	
More than 1 year after becoming concerned	16.8	9	12.5	(6.5 – 22.6)	9	25.7	(13.5 – 43.5)	
Did not seek help	18.7	12	16.7	(9.6 – 27.4)	8	22.9	(11.4 – 40.5)	
Last sought help for own mental health problems*								0.63
Currently seeking help	21.5	18	25.0	(16.2 – 36.5)	5	14.3	(5.8 – 31.1)	
Not currently, but in last 12 months	8.4	6	8.3	(3.7 – 17.6)	< 5	8.6	(2.6 – 24.6)	
Not currently, but 12+ months ago	53.3	37	51.4	(39.7 – 62.9)	20	57.1	(39.7 – 72.9)	
Never sought help	16.8	11	15.3	(8.5 – 25.8)	7	20.0	(9.5 – 37.4)	
Knew where to get help for their own mental health problems†	89.7	53	88.3	(77.1 – 94.5)	25	92.6	(72.8 – 98.3)	0.55

* Only asked of parents who were concerned about own mental health (All n = 107; Current n = 72; Ex-serving n = 35).

† Only asked of parents who had ever sought help for own mental health (All n = 87; Current n = 60; Ex-serving n = 27).

Note: 95% CI = 95% confidence interval. SE = standard error.

3.4.5 Concerns about ADF members' mental health and assistance provided

Just over half of all parents had been concerned at some stage about their ADF sons'/daughters' mental health (54.6%), with the average length of time since they had first been concerned being 6.6 years (Table 3.41). Parents of Ex-Serving ADF members tended to significantly more often have been concerned (68.8% compared with 47.5%) and to have first become concerned a longer time ago, with 50.0% of parents of Ex-

Serving ADF members having first become concerned between 5 and 9 years ago, compared with 24.1% of those with Current Serving sons/daughters.

When parents who had been concerned about their ADF sons'/daughters' mental health were asked whether they had provided assistance, 64.6% reported doing so. Parents of Current Serving ADF members were less likely to have provided assistance at some stage than parents of Ex-Serving ADF members (40.7% compared with 28.6%; Table 3.41). Of those parents who had provided assistance, 81.7% had encouraged ADF members to seek help for mental health problems. Significantly more parents of Ex-Serving than Current Serving ADF members had encouraged their ADF sons/daughters to seek help.

Table 3.41 Concerns about ADF members' mental health reported by parents and assistance provided, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Ever been concerned about ADF member's mental health	54.8	84	47.5	(40.1 – 54.9)	64	68.8	(58.5 – 77.5)	0.0008
Number of years since first became concerned about ADF member's mental health*								
Number of years (mean, SE)	0.5	7.3	0.7	(5.9 – 8.8)	5.7	0.5	(4.7 – 6.7)	0.09
Number of years								0.0006
≤ 1 year	8.8	8	9.6	(4.8 – 18.3)	5	7.8	(3.2 – 17.8)	
2 years	10.2	13	15.7	(9.2 – 25.4)	< 5	3.1	(0.8 – 12.1)	
3 years	13.6	13	15.7	(9.2 – 25.4)	7	10.9	(5.2 – 21.6)	
4 years	12.9	7	8.4	(4.0 – 16.9)	12	18.8	(10.8 – 30.5)	
5–9 years	35.4	20	24.1	(16.0 – 34.7)	32	50.0	(37.7 – 62.3)	
10+ years	19.1	22	26.5	(18.0 – 37.2)	6	9.4	(4.2 – 19.7)	
Provided assistance for ADF member's mental health*								0.02
Currently providing assistance	22.9	13	16.0	(9.4 – 26.0)	20	31.7	(21.2 – 44.5)	
In last 12 months	13.9	8	9.9	(4.9 – 18.8)	12	19.0	(11.0 – 31.0)	
12+ months ago	27.8	27	33.3	(23.8 – 44.5)	13	20.6	(12.2 – 32.7)	
Never provided assistance	35.4	33	40.7	(30.4 – 52.0)	18	28.6	(18.6 – 41.2)	
Assistance included encouraging ADF member to get help for mental health†	81.7	37	77.1	(62.6 – 87.1)	39	86.7	(72.7 – 94.1)	0.23

* Only asked of parents who were concerned about ADF member's mental health (All n = 148; Current n = 84; Ex-serving n = 64).

† Only asked of parents who provided assistance (All n = 93; Current n = 48; Ex-serving n = 45).

Note: 95% CI = 95% confidence interval. SE = standard error.

3.4.6 Summary

We next provide a summary of the findings relating to the parents of Ex-Serving and Current Serving ADF members. First, an overview of all parents is provided, followed by a description of the aspects on which parents of Ex-Serving and Current Serving sons/daughters were found to differ. Finally, differences between the Ex-Serving and Current Serving sons/daughters of responding parents according to parent reports are described.

Overall

Parents' demographic background

- FWS responding parents were most commonly 58 or more years of age (70.9%), with almost all other parents being 48 to 57 years (28.0%).
- 68.7% were female.
- 38.5% had attained a certificate/diploma, 33.1% a university degree, and 28.4% reported their highest level of education to be primary or secondary school.

Service history

- 15.6% of parents had themselves been a member of the ADF or were currently a member.
- 37.1% of parents' parents (i.e. ADF members' grandparents) had experienced military service.

Impact of military service

- A majority of parents saw the impact of military service on ADF members as having been positive on their employment, financial situation, and careers. Around half of parents thought it had been a positive influence on ADF members' relationships with their partner, other immediate family members, wider family and friends, and their physical and mental health.
- The majority felt that ADF members' military service had no effect on parents' wellbeing (between 53.8% and 86.6% over the various aspects).

Physical health and quality of life

- 8.4% of parents reported their general physical health had been poor or very poor in the past 12 months.
- Only 2.9% felt their current quality of life had been poor or very poor.

Involvement in risk-taking

- 8.1% reported drinking at problem levels in the last 12 months.
- 8.7% had used illicit drugs in their lifetime, 1.4% in the past 12 months.
- 31.4% had gambled during the past 12 months, but only 4.7% showed signs of problem gambling.

Mental health

- 14.4% of parents reported high to very high levels of psychological distress in the past 4 weeks.
- 11.9% of parents reported high levels of PTSD symptoms in the same time period.
- 10.6% of parents had shown signs of suicidality in the past 12 months, while 2.6% had made a plan or attempted suicide in this time frame.

Concerns about their own mental health, help seeking

- 40.1% of parents had been concerned about their own mental health during their lifetime.
- The average number of years since parents first became concerned was 15.5 years.
- 81.3% of those who had been concerned had sought help, and 89.7% of those with concerns knew where to obtain help.

Concerns about ADF members' mental health

- 54.8% of parents had been concerned about their ADF sons'/daughters' mental health at some point, with them first becoming concerned on average 6.6 years ago.
- Of parents who had been concerned about their ADF sons'/daughters' mental health, 64.6% had provided assistance at some stage.
- Of parents who had provided assistance to their ADF sons/daughters to seek help, 81.7% encouraged them to seek help for mental health problems.

Significant differences between parents of Current Serving and Ex-Serving ADF members

Parents of Current Serving or Ex-Serving sons/daughters were compared on the above aspects. There were no significant differences on most aspects: parents' age, educational background, family history of military service, risk-taking, current quality

of life, physical and mental health, rates of concerns about their own mental health over their lifetime, and help seeking. Only two significant differences were found:

- **Gender** – A higher percentage of parents of Ex-Serving ADF members were female.
- **Effect of ADF members' military service on parents** – While the majority of parents felt there had been no effect of their ADF sons'/daughters' military service on themselves, a significantly higher percentage of those with Ex-Serving sons'/daughters' perceived there had been negative effects on themselves across all areas assessed, except parents' relationships with friends.

Significant differences between Current Serving and Ex-Serving ADF members according to parents

The following differences between Current Serving and Ex-Serving ADF members were found:

- **Effect of ADF members' military service on ADF members** – A significantly higher percentage of parents of Current Serving ADF members perceived there had been a positive influence on their ADF sons'/daughters' relationship with their spouse/partner than parents of Ex-Serving ADF sons'/daughters. For all other areas assessed, a significantly higher percentage of parents of Ex-Serving ADF members perceived there to be negative effects on ADF members, including relationships with other immediate family members and wider family, mental and physical health, and their employment, finances and careers.
- **Concerns about ADF members' mental health** – Significantly more parents had been concerned about their Ex-Serving sons'/daughters' mental health and had first become concerned a longer time ago.
- **Assistance for mental health problems** – Parents of Ex-Serving ADF members were significantly more likely to have provided assistance for mental health problems.

4 Factors associated with military families' health and functioning

In Chapter 3, the demographic and background characteristics of the military families participating in the FWS were summarised overall and by military status of their ADF members (Current Serving or Ex-Serving). However, the analyses looked at the independent effects of each factor, without simultaneously taking into account the effects of other potentially influential factors.

The analyses in Chapter 4 aim to identify the factors that are significantly related to outcomes, while controlling for the effects of other salient factors. They can provide a more complete understanding of the relevance of each factor for the outcomes studied. This section investigates associations between the following four major outcome areas and a range of family and FWS participant background characteristics, ADF members' characteristics and military service-related factors:

1. health and wellbeing of all family members
2. couple relationships
3. parenting
4. child behaviour.

4.1 Method

4.1.1 Samples

Only family members whose ADF members had agreed to have their survey responses from the Mental Health and Wellbeing Transition Study (MHWTS) linked to their Family Wellbeing Study (FWS) family members' FWS responses were included in the analyses. To investigate the four major outcome areas, the following analysis samples were used:

- to investigate the health and wellbeing of military family members – 'Sample 2: Linked family data' with the following exclusions: ex-spouses/ex-partners and those who described their relationship as 'other' (and their ADF members)
- to investigate couple relationships – 'Sample 4: Linked spouse/partner data' with the exclusion of ex-spouses/ex-partners (and their ADF members)

- to investigate FWS spouses'/partners' parenting practices – 'Sample 4: Linked spouse/partner data' with the exclusion of spouses/partners (and their ADF members) who did not have dependent children aged 2 to 17 years with their ADF members
- to investigate the behaviour of children aged 2 to 17 years – 'Sample 4: Linked spouse/partner data' with the exclusion of spouses/partners (and their ADF members) who did not have dependent children aged 2 to 17 years with their ADF members.

For reader ease, when referring to FWS respondents' nominators (MHWTS respondents with family members), we use the term 'ADF members' unless otherwise stated, although we recognise that those who are Ex-Serving are technically no longer ADF members. It should also be noted that because the ADF members whose families participated in the FWS were not completely representative of the wider Programme population from which they were derived, caution is needed when generalising study findings beyond the FWS sample.

4.1.2 Variables

All the variables used in the multivariate analyses are described in Chapter 2, with further details also provided in appendixes G to J and in sections 4.2, 4.4, 4.6 and 4.8 hereafter.

Outcomes

Mental health and problem drinking outcomes

Three binary outcomes based on data for all FWS family members were examined: psychological distress, posttraumatic stress disorder (PTSD), and problem drinking. The outcomes were defined as follows:

- Family members were considered to have psychological distress if they scored ≥ 22 on the Kessler Psychological Distress 10-item scale (K10) (Kessler et al., 2002).
- PTSD was assessed using the Posttraumatic Stress Disorder Checklist – civilian version (PCL-C) (Weathers et al., 1993), with those scoring ≥ 40 considered to have high levels of PTSD symptoms.
- Problem drinking was assessed using the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993), with those scoring ≥ 8 identified as problem drinkers.

Couple relationship outcomes

For current spouses/partners, three relationship measures were used: relationship happiness, relationship quality, and whether there had ever been abuse in the couple relationship.

- Spouses/partners who rated their couple relationship as ‘extremely unhappy’, ‘fairly unhappy’ and ‘a little unhappy’ were considered to be in unhappy relationships.
- Relationship quality was measured by the 7-item Relationship Assessment Scale (Hendrick, 1988), with an overall, continuous mean score calculated which could range from 1 (low satisfaction) to 5 (high satisfaction).
- Abuse in couple relationships was assessed using the 8-item Woman Abuse Screening Tool (Brown et al., 2000), with those scoring > 14 considered to have experienced abuse at some stage of their couple relationship.

Parenting practices outcomes

Spouses/partners of children aged less than 18 years were asked about their parenting practices, with the measures used capturing the major parenting dimensions of consistency, warmth, hostility, and use of reasoning. Parenting self-efficacy was also assessed to measure how the parents felt they were going as parents (Gray & Sanson, 2005). Mean scores were calculated which could range from 1 to 5, with higher scores indicating greater consistency, warmth, hostility, use of reasoning, and self-efficacy.

Child behaviour outcome

Spouses/partners of children aged 2 to 17 years were asked about their child’s behaviour problems and competencies using the 25-item Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1995). The SDQ provides cut-offs to identify children in the normal, borderline and abnormal range, which were used to create a binary total behaviour problem outcome. The outcome differentiated children showing ‘abnormal’ levels of behaviour problems from those showing ‘normal/borderline’ levels of behaviour problems.

FWS respondent demographic and background measures

The FWS respondent measures used for each analysis are summarised in Table 4.1. We first discuss some constraints concerning the variables that could be included in the statistical analyses.

There was a very high correspondence between ADF membership and FWS respondents’ sex, as almost all ADF members were male and a very large percentage of FWS respondents were female, especially if they were their ADF members’ spouses/partners. These variables were so highly correlated that they explained each

other (i.e. one variable can be used to predict the other variable), and both variables could not be included in the same analysis. Decisions had to be made about which associations were of most interest. As a key interest of the FWS was the type and extent of differences between the families of Current Serving and Ex-Serving ADF members, FWS respondent sex had to be dropped from the analyses undertaken so that the military status of ADF members could be retained.

FWS respondent age could not be included in the analyses of family members' mental health and risk-taking as it was highly associated with how FWS respondents were related to their ADF members, which was of greater importance. In particular, young FWS respondents were predominantly the adult children of their ADF members, middle-aged FWS respondents were likely to be their spouses/partners, and older FWS respondents were likely to be the parents of ADF members. This issue did not arise for the analyses that only used spouse/partner data (couple relationships, parenting and child behaviour); hence, respondents' age was included as a categorical measure in these latter analyses.

Additionally, some variables could not be included due to high levels of missing data (for example, residential mobility).

Some other variable treatments are next noted.

A four-level variable was created to jointly capture FWS respondents' poor physical health and psychological distress for the analyses examining couple relationships, parenting and child behaviour. The Kessler K10 cut-offs were used to identify those with 'moderate' to 'very high' psychological distress, while those who rated their physical health over the past 12 months as 'poor' or 'very poor' were considered to have poor physical health. The variable created was (1) neither problem (reference category), (2) poor physical health only, (3) psychological distress only, and (4) poor physical health and psychological distress.

For the parenting and child behaviour analyses, the age of the child in years was included as a continuous measure.

In all models, a criterion of a household size of five or more people was used to indicate a larger family size.

In the analyses of child behaviour problems, two parenting domains that are known to be highly related to behaviour problems were included – consistency and hostility.

Table 4.1 Summary of FWS respondent measures used in each analysis

Measure*	Analysis			
	Mental health, risk-taking	Couple relationships	Parenting	Child behaviour
Relationship to ADF member	✓	✗	✗	✗
Age	✗	✓	✓	✓
Has a child with ADF member	✗	✓	✗	✗
Child's age	✗	✗	✓	✓
Education	✓	✓	✓	✓
Poor physical health	✓	✗	✗	✗
Mental and physical health problems	✗	✓	✓	✓
5+ people in household	✓	✓	✓	✓
Unemployed	✓	✓	✓	✓
Has served in the ADF	✓	✓	✓	✓
Parenting consistency	✗	✗	✗	✓
Parenting hostility	✗	✗	✗	✓

* All measures relate to the FWS respondent unless stated otherwise.

ADF member demographic, background and military service measures

The ADF member measures shown in Table 4.2 were used in all analyses. These measures were derived based on ADF members' responses collected in the MHWTS. Continuous measures were used for years served in the ADF and the number of traumas experienced. A binary indicator was derived to identify those who had never been deployed compared to those who had been deployed one or more times. ADF members' poor physical health and psychological distress were combined as described above to create a four-level variable: (1) neither problem (reference category), (2) poor physical health only, (3) psychological distress, and (4) poor physical health and psychological distress.

Table 4.2 Summary of ADF member measures used in each analysis

Measure	Analysis			
	All family	Couples	Parenting	Child behaviour
Military status	✓	✓	✓	✓
Rank	✓	✓	✓	✓
Service type	✓	✓	✓	✓
Years served in ADF	✓	✓	✓	✓
Never deployed	✓	✓	✓	✓
Medical fitness for service	✓	✓	✓	✓
Mental and physical health problems	✓	✓	✓	✓
Problem drinking	✓	✓	✓	✓
Number of traumas experienced	✓	✓	✓	✓

A number of demographic variables were not able to be included in the analyses. Similarly to FWS respondents, sex and age of ADF members were not included as they were highly related to other variables of greater importance. It was also not possible to include ADF members' PTSD as it was highly associated with their mental and physical wellbeing, deployment and fitness for service.

4.1.3 Statistical methods

All outcome measures were summarised with the prevalence being calculated for the categorical measures and the mean calculated for continuous measures. In addition, the demographic and background measures were summarised for each outcome measure (see appendixes G to J). A modelling framework was used to examine the associations between FWS respondent and ADF member predictor measures and each outcome. It should be noted that while the multivariate models can shed light on associations between predictor variables and outcomes, they cannot determine causality (what leads to what), especially as the predictor variables and outcomes were measured at the same point in time.

For the analysis of the health and wellbeing outcomes of all family members, logistic generalised estimating equations (Liang & Zeger, 1986) with robust standard errors were used. These models allowed investigation of predictive associations between FWS respondent, and ADF member factors, and FWS respondent's health and wellbeing, taking into account the clustering of family members within each ADF member. (ADF members could nominate up to three family members for participation in the FWS, and, as shown in Chapter 2, there were 82 instances of multiple nominations. Overall, approximately 170 FWS participants had other family members take part in the FWS.) It was assumed that family members who were nominated by the same ADF member would be more similar in their responses than family members who were nominated by another ADF member.

For the spouse, parenting and child behaviour outcomes, generalised linear models were used to estimate associations, as few ADF members had multiple respondents and so it was not necessary to take into account the clustering of respondents within ADF members.

Logistic regression models were used for the binary outcomes of unhappy couple relationship, abuse in couple relationships and child behaviour problems. Logistic models estimate odds ratios, which is a measure of association between the predictor and the outcome. For categorical predictor variables, the odds ratio represents the odds that a respondent will have the outcome (e.g. psychological distress) if they have a particular predictor present (e.g. ADF member), compared to the odds of having the outcome in the absence of that predictor (e.g. no psychological distress). For the continuous predictor measures (e.g. years served in the ADF), the odds ratio is

associated with a one-unit increase in the measure. When the odds ratio is greater than one, the predictor is associated with higher odds of the outcome being present (e.g. having psychological distress). When the odds ratio is less than one, the exposure is associated with lower odds of the outcome occurring. Ninety-five per cent confidence intervals and *p*-values are used to assess if the odds ratios are statistically different from one, and to assess the strength of the association.

Linear regression models were used for the continuous outcomes of couple relationship quality and parenting practices. Linear regression coefficients (betas) represent the mean change in the response variable for one unit of change in the predictor variable. Ninety-five per cent confidence intervals and *p*-values are used to assess if linear regression coefficients are different from zero, and to assess the strength of the association.

The models were fitted in three separate stages:

1. each separate predictor variable was fitted separately
2. all FWS family member factors were jointly fitted
3. all FWS family member and ADF member factors were fitted jointly.

All main effects were tested for statistical significance using the Wald test. For measures with multiple categories, a joint test of significance was used to assess if the overall measure was associated with the outcome. For each analysis, respondents were included in the analysis sample if they had complete ADF member and family member background data and at least one outcome. Data were analysed using Stata 15 (StataCorp, 2017).

4.2 Samples and variables used in multivariate analyses of family members' mental health and problem drinking

Of the 1,217 FWS respondents who comprised 'Sample 2: Linked family data', 20 were ex-spouses or ex-partners and 24 were family members who described their relationship to the ADF member as 'other'. These respondents were excluded from the analyses. Of the resulting 1,173 family members (spouses/partners, parents and adult children), 30 respondents (3%) did not have complete data for the demographic, background and military predictor variables or were missing key outcome variables, and were therefore also excluded from the analyses. The resulting sample comprised the 1,143 FWS respondents with complete data on predictor variables and at least one outcome variable.

Table 4.3 shows the characteristics of the FWS respondent sample and their ADF members used in the modelling analyses.

Table 4.3 FWS respondent and ADF member characteristics (n = 1,143)

Measure	n	%
FWS RESPONDENT		
Male sex	160	14.0
Age (years)		
18 – < 28	95	8.3
28 – < 38	262	22.9
38 – < 48	292	25.5
48 – < 58	290	25.4
58+	204	17.8
Relationship to ADF member		
Spouse/partner	828	72.4
Parent	224	19.6
Adult child (18+ years)	91	8.0
Education		
University degree	483	42.3
Certificate/diploma	398	34.8
Primary/secondary school	262	22.9
Poor physical health	143	12.5
5+ people in household	159	13.9
Unemployed	386	33.8
Has served in the ADF	191	16.7
ADF MEMBER		
Military status		
Current Serving	778	68.1
Active reservist	118	10.3
Inactive reservist	114	10.0
Discharged from ADF	133	11.6
Rank		
Commissioned Officer	563	49.3
Non-commissioned Officer	492	43.0
Other rank	88	7.7
Service type		
Navy	246	21.5
Army	521	45.6
Air Force	376	32.9
Years served in the ADF (mean, SD)	18.9	9.8
Never deployed	122	10.7
Medically unfit for service	227	19.9
Mental and physical health problems		
Neither problem	755	66.1
Poor physical health	138	12.1
High psychological distress	85	7.4
Poor physical health and high psychological distress	165	14.4
Problem drinking	272	23.8
Number of traumas experienced (mean, SD)	3.3	2.8

Note: SD = standard deviation.

Table 4.4 shows prevalences on the health and wellbeing outcomes. Further details of the FWS respondent and ADF member characteristics, stratified by each outcome, are shown in Appendix G.

Table 4.4 Percentages showing problematic outcomes

Measure	N	n	%
High/very high psychological distress (K10)	1,115	191	17.1
High levels of PTSD symptoms (PCL-C)	1,117	99	8.9
Problem drinking (AUDIT)	1,124	113	10.1

4.3 Findings from the multivariate modelling of mental health outcomes and problem drinking

4.3.1 Psychological distress

When looked at separately, the following FWS family member characteristics were all individually associated with family member psychological distress: their relationship to their ADF members, level of education, presence of poor physical health, and having served in the ADF (Table 4.5). Of the ADF member background characteristics and military service-related factors included, only ADF members' rank was significantly associated with family member psychological distress.

In the model where all family member and ADF member measures were jointly fitted, all these associations remained, with the exception of FWS family members' level of education. After taking into account all other factors, there was statistical evidence that:

- adult children had two and a half times greater odds of being psychologically distressed compared to spouses/partners (OR = 2.56)
- FWS family members with poor physical health were six times more likely to be psychologically distressed compared to those with reasonable or good physical health (OR = 6.12)
- FWS family members who themselves had served in the ADF had one and three-quarter times greater odds of psychological distress (OR = 1.76) compared to those who had no ADF service
- FWS family members whose ADF member rank was classified as 'other' had twice the risk of psychological distress (OR = 2.26) compared to family members whose ADF member was a Commissioned Officer.

There was no statistical evidence that any other ADF member background or military service characteristic was related to their family members' psychological distress.

4.3.2 Posttraumatic stress disorder

When examined individually, the ADF member characteristics found to be significantly associated with FWS respondents' PTSD were rank, service type and years of service (Table 4.6). FWS respondents' level of education, poor physical health and own service in the ADF were also found to be significantly associated with high levels of PTSD symptoms when examined separately.

The joint analyses showed that the effects of two factors (FWS respondents' education and ADF members' rank) were attenuated after taking into account the contribution of other variables. All other effects remained statistically significant, as follows:

- FWS respondents with poor physical health had five times greater odds of PTSD (OR = 5.44) than those in reasonable or good physical health.
- FWS respondents who had served in the ADF also had an increased risk of PTSD (OR = 2.08) compared to FWS respondents with no service history.
- FWS respondents of ADF members who had served in the Navy had an increased risk of PTSD (OR = 2.28) compared to those whose ADF members had served in the Army.
- ADF members' length of service was associated with a decreased risk of PTSD among family members, with each one-year increase in service decreasing the odds of PTSD by 3%.

4.3.3 Problem drinking

When examined separately, family members' problem drinking was found to be associated with how they were related to ADF members (i.e. whether they were spouses/partners, adult children, or parents), their poor physical health, and ADF members' problem drinking (Table 4.7). The joint model showed that:

- adult children had an increased risk of problem drinking (OR = 2.33) compared to spouses/partners
- FWS respondents with poor physical health had more than two times greater risk of problem drinking (OR = 2.53) than those in reasonable or good physical health
- ADF members' drinking was associated with FWS respondents' problem drinking. The odds of problem drinking were about 64% higher for FWS respondents whose ADF members were problem drinkers by comparison with those whose ADF members were not problem drinkers.

There was no evidence that military service factors were associated with FWS respondents' problem drinking.

Table 4.5 FWS respondent and ADF member predictors of FWS respondents' psychological distress

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS RESPONDENT									
Relationship to ADF member			0.008*			0.001*			0.005*
Spouse/partner (reference)	1.00			1.00			1.00		
Parent	0.90	(0.60 – 1.37)		0.92	(0.59 – 1.44)		0.96	(0.59 – 1.55)	
Adult child aged 18+	2.10	(1.28 – 3.44)		2.62	(1.53 – 4.49)		2.56	(1.45 – 4.51)	
Education			0.007*			0.19*			0.46*
University degree (reference)	1.00			1.00			1.00		
Certificate/diploma	1.75	(1.21 – 2.52)		1.42	(0.96 – 2.11)		1.29	(0.86 – 1.95)	
Primary/secondary school	1.62	(1.08 – 2.45)		1.35	(0.87 – 2.11)		1.20	(0.75 – 1.92)	
Poor physical health	6.69	(4.57 – 9.81)	< 0.0001	6.58	(4.43 – 9.75)	< 0.0001	6.12	(4.07 – 9.21)	< 0.0001
5+ people in household	0.82	(0.51 – 1.32)	0.42	0.84	(0.50 – 1.42)	0.52	0.85	(0.50 – 1.44)	0.55
Unemployed	1.29	(0.93 – 1.78)	0.12	1.15	(0.80 – 1.64)	0.45	1.14	(0.79 – 1.64)	0.47
Has served in the ADF	1.67	(1.14 – 2.44)	0.008	1.66	(1.10 – 2.50)	0.02	1.76	(1.15 – 2.68)	0.009
ADF MEMBER									
Military status			0.32*						0.94*
Current Serving (reference)	1.00						1.00		
Active reservist	1.06	(0.62 – 1.81)					1.05	(0.59 – 1.88)	
Inactive reservist	1.07	(0.62 – 1.83)					0.96	(0.53 – 1.72)	
Discharged from ADF	1.55	(0.98 – 2.45)					1.18	(0.66 – 2.11)	
Rank			0.0002*						0.05*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	1.68	(1.19 – 2.36)					1.32	(0.89 – 1.95)	
Other rank	2.73	(1.61 – 4.65)					2.26	(1.15 – 4.47)	

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	<i>p</i> -value	OR	(95% CI)	<i>p</i> -value	OR	(95% CI)	<i>p</i> -value
Service type			0.75*						0.79*
Army (reference)	1.00						1.00		
Navy	0.86	(0.57 – 1.31)					0.85	(0.53 – 1.37)	
Air Force	0.91	(0.63 – 1.31)					0.92	(0.61 – 1.40)	
Years served in the ADF	1.00	(0.99 – 1.02)	0.59				1.01	(0.99 – 1.03)	0.58
Never deployed	0.83	(0.48 – 1.42)	0.49				1.08	(0.59 – 1.98)	0.80
Medically unfit for service	1.40	(0.96 – 2.04)	0.08				0.95	(0.59 – 1.52)	0.82
Mental and physical health problems			0.08*						0.97*
Neither problem (reference)	1.00						1.00		
Poor physical health	1.53	(0.95 – 2.45)					1.01	(0.59 – 1.74)	
High psychological distress	1.54	(0.87 – 2.75)					1.28	(0.67 – 2.43)	
Poor physical health and high psychological distress	2.13	(1.40 – 3.23)					1.43	(0.83 – 2.45)	
Problem drinking	0.95	(0.65 – 1.38)	0.79				0.80	(0.52 – 1.24)	0.33
Number of traumas experienced	1.04	(0.99 – 1.10)	0.13				1.02	(0.96 – 1.09)	0.48

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

Table 4.6 FWS respondent and ADF member predictors of FWS respondents' PTSD

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS RESPONDENT									
Relationship to ADF member			0.09*			0.05*			0.18*
Spouse/partner (reference)	1.00			1.00			1.00		
Parent	1.68	(1.04 – 2.72)		1.85	(1.10 – 3.10)		1.46	(0.83 – 2.57)	
Adult child aged 18+ years	1.46	(0.71 – 2.99)		1.67	(0.77 – 3.60)		1.84	(0.79 – 4.28)	
Education			0.02*			0.11*			0.19*
University degree (reference)	1.00			1.00			1.00		
Certificate/diploma	1.91	(1.19 – 3.06)		1.57	(0.95 – 2.58)		1.45	(0.86 – 2.45)	
Primary/secondary school	1.15	(0.64 – 2.07)		0.96	(0.52 – 1.79)		0.91	(0.48 – 1.75)	
Poor physical health	5.68	(3.60 – 8.95)	< 0.0001	5.72	(3.56 – 9.18)	< 0.0001	5.44	(3.29 – 9.00)	< 0.0001
5+ people in household	0.75	(0.39 – 1.45)	0.39	0.82	(0.40 – 1.65)	0.58	0.82	(0.39 – 1.72)	0.60
Unemployed	1.07	(0.70 – 1.65)	0.75	0.89	(0.56 – 1.41)	0.61	0.91	(0.56 – 1.46)	0.69
Has served in the ADF	2.01	(1.25 – 3.23)	0.004	1.83	(1.10 – 3.02)	0.02	2.08	(1.22 – 3.53)	0.007
ADF MEMBER									
Military status			0.10*						0.33*
Current Serving (reference)	1.00						1.00		
Active reservist	0.93	(0.45 – 1.96)					1.17	(0.52 – 2.62)	
Inactive reservist	0.74	(0.33 – 1.68)					0.74	(0.30 – 1.87)	
Discharged from ADF	1.88	(1.08 – 3.29)					1.82	(0.87 – 3.81)	
Rank			0.01*						0.70*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	1.56	(0.99 – 2.45)					1.24	(0.73 – 2.10)	
Other rank	2.69	(1.38 – 5.25)					1.30	(0.54 – 3.13)	

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Service type			0.002*						0.005*
Army (reference)	1.00						1.00		
Navy	2.09	(1.28 – 3.42)					2.28	(1.30 – 4.01)	
Air Force	0.89	(0.52 – 1.52)					0.97	(0.53 – 1.76)	
Years served in ADF	0.98	(0.95 – 1.00)	0.03				0.97	(0.94 – 1.00)	0.05
Never deployed	0.42	(0.17 – 1.07)	0.07				0.41	(0.15 – 1.19)	0.10
Medically unfit for service	1.36	(0.53 – 2.23)	0.22				0.80	(0.42 – 1.55)	0.51
Mental and physical health problems									
Neither problem (reference)	1.00		0.88*				1.00		0.36*
Poor physical health	1.05	(0.53 – 2.09)					0.69	(0.32 – 1.52)	
High psychological distress	1.51	(0.71 – 3.21)					1.45	(0.63 – 3.34)	
Poor physical health and high psychological distress	2.01	(1.19 – 3.42)					1.43	(0.70 – 2.92)	
Problem drinking	0.89	(0.54 – 1.48)	0.66				0.74	(0.41 – 1.33)	0.32
Number of traumas experienced	1.00	(0.93 – 1.08)	0.94				1.01	(0.92 – 1.10)	0.84

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

Table 4.7 FWS respondent and ADF member predictors of FWS respondents' problem drinking

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS RESPONDENT									
Relationship to ADF member			0.02*			0.02*			0.03*
Spouse/partner (reference)	1.00			1.00			1.00		
Parent	0.83	(0.49 – 1.42)		0.83	(0.48 – 1.43)		0.88	(0.49 – 1.59)	
Adult child aged 18+ years	2.14	(1.20 – 3.81)		2.25	(1.23 – 4.10)		2.33	(1.23 – 4.42)	
Education									
University degree (reference)	1.00		0.09*	1.00		0.17*	1.00		0.20*
Certificate/diploma	1.65	(1.06 – 2.58)		1.54	(0.98 – 2.44)		1.50	(0.93 – 2.42)	
Primary/secondary school	1.28	(0.76 – 2.16)		1.17	(0.68 – 2.02)		1.09	(0.61 – 1.93)	
Poor physical health	2.45	(1.52 – 3.93)	0.0002	2.44	(1.50 – 3.99)	0.0003	2.53	(1.51 – 4.22)	0.0004
5+ people in household	0.58	(0.30 – 1.14)	0.11	0.58	(0.29 – 1.15)	0.12	0.60	(0.30 – 1.21)	0.15
Unemployed	0.80	(0.52 – 1.22)	0.29	0.77	(0.49 – 1.20)	0.25	0.78	(0.50 – 1.24)	0.30
Has served in the ADF	1.38	(0.86 – 2.24)	0.19	1.33	(0.81 – 2.17)	0.26	1.38	(0.84 – 2.27)	0.21
ADF MEMBER									
Military status			0.52*						0.81*
Current Serving (reference)	1.00						1.00		
Active reservist	1.01	(0.52 – 1.98)					0.94	(0.47 – 1.89)	
Inactive reservist	1.37	(0.74 – 2.53)					1.23	(0.65 – 2.36)	
Discharged from ADF	1.43	(0.81 – 2.52)					1.31	(0.66 – 2.62)	
Rank			0.45*						0.66*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	1.25	(0.84 – 1.87)					1.05	(0.67 – 1.64)	
Other rank	0.87	(0.38 – 1.99)					0.69	(0.27 – 1.77)	
Service type			0.24*						0.27*
Army (reference)	1.00						1.00		

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Navy	1.02	(0.63 – 1.67)					1.16	(0.68 – 1.95)	
Air Force	0.69	(0.43 – 1.10)					0.73	(0.44 – 1.22)	
Years served in ADF	1.01	(0.99 – 1.03)	0.15				1.01	(0.98 – 1.03)	0.59
Never deployed	0.71	(0.35 – 1.44)	0.34				1.02	(0.47 – 2.18)	0.97
Medically unfit for service	1.28	(0.81 – 2.03)	0.29				1.13	(0.66 – 1.96)	0.65
Mental and physical health problems			0.76*						0.46*
Neither problem (reference)	1.00						1.00		
Poor physical health	1.10	(0.60 – 2.02)					0.78	(0.41 – 1.51)	
High psychological distress	1.31	(0.65 – 2.66)					1.01	(0.47 – 2.15)	
Poor physical health and high psychological distress	1.27	(0.74 – 2.17)					0.75	(0.39 – 1.46)	
Problem drinking	1.72	(1.14 – 2.61)	0.01				1.64	(1.04 – 2.61)	0.03
Number of traumas experienced	1.06	(1.00 – 1.13)	0.07				1.03	(0.96 – 1.11)	0.40

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

4.4 Samples and variables used in the multivariate modelling of couple relationships

Of the 868 spouses/partners included in 'Sample 4: Linked spouse/partner data', 20 were ex-spouses or ex-partners, and therefore were excluded from the analyses. Of the resulting 848 spouses/partners, 45 (5%) did not have complete data for the demographic, background and military predictor variables or were missing all outcome variables, and therefore were also excluded. The resulting sample comprised 803 current spouses/partners with complete data on predictor variables and at least one outcome variable.

For the modelling, recoding of some predictor variables was necessary to avoid low numbers in some categories, especially as further differentiation was needed for some variables (e.g. into abuse/no abuse in relationships). Spouses'/partners' age needed to be recoded into broader categories (Table 4.8 indicates that the numbers were problematic for the youngest and oldest categories), and ADF members who had left the ADF were combined into a single Ex-Serving category.

Table 4.8 shows the characteristics of the spouse/partner sample used in the modelling analyses.

Table 4.8 Spouse/partner and ADF member characteristics (n = 803)

Measure	n	%
FWS RESPONDENT		
Male	66	8.2
Age (years)		
18 – < 38	31	3.9
28 – < 38	227	28.3
38 – < 48	281	35.0
48 – < 58	221	27.5
58+	43	5.4
Does not have a dependent child with ADF member	149	18.6
Education		
University degree	374	46.6
Certificate/diploma	276	34.4
Primary/secondary school	153	19.1
Mental and physical health problems		
Neither problem	613	76.3
Poor physical health	59	7.3
High psychological distress	79	9.8
Poor physical health and high psychological distress	52	6.5

Measure	n	%
5+ people in household	138	17.2
Unemployed	256	31.9
Has served in the ADF	141	17.6
ADF MEMBER		
Ex-serving	248	30.9
Rank		
Commissioned Officer	389	48.4
Non-commissioned Officer	360	44.8
Other rank	54	6.7
Service type		
Navy	167	20.8
Army	368	45.8
Air Force	268	33.4
Years served in the ADF (mean, SD)	19.8	9.6
Never deployed	78	9.7
Medically unfit for service	138	17.2
Mental and physical health problems		
Neither problem	531	66.1
Poor physical health	100	12.5
High psychological distress	65	8.1
Poor physical health and high psychological distress	107	13.3
Problem drinking	186	23.2
Number of traumas experienced (mean, SD)	3.4	2.8

Note: Numbers and percentages shown unless otherwise stated. SD = standard deviation.

The three outcome measures are summarised in Table 4.9. A total of 21.8% of spouses/partners rated their couple relationship as being unhappy. A mean score of 4.2 was found for relationship quality, as measured on the 7-item Relationship Assessment Scale (Hendrick, 1988), which ranged from 1 (low satisfaction) to 5 (high satisfaction). The mean score was at the positive end of the scale, indicating that relationships were generally strong. A small percentage (4.8%) reported abuse had occurred at some stage in their current couple relationship using the 8-item Woman Abuse Screening Tool (Brown et al., 2000). Spouse/partner and ADF member characteristics, stratified by the binary outcome measures of an unhappy relationship and whether abuse had ever occurred, are shown in Appendix H. Mean relationship quality scores have been calculated for each categorical predictor variable and are also shown in Appendix H.

Table 4.9 Frequency of outcomes (n = 803)

Measure	N	n	%
Unhappy couple relationship	803	175	21.8
Couple relationship quality (mean, SD)	793	4.2	0.7
Abuse at some stage of couple relationship	797	38	4.8

Note: Numbers and percentages shown unless otherwise stated. SD = standard deviation.

4.5 Findings from the multivariate modelling of couple relationships

4.5.1 Unhappiness in couple relationships

When predictor variables were fitted separately, only FWS spouses'/partners' and ADF members' mental and physical health problems were statistically associated with an unhappy couple relationship (Table 4.10).

When fitted jointly, only FWS spouses'/partners' mental and physical health problems were statistically associated with being in an unhappy relationship, but ADF members' mental and physical health problems were not. Spouses/partners who were psychologically distressed but did not have poor physical health had almost three times greater odds of being in an unhappy couple relationship (OR = 2.84), while spouses/partners who were psychologically distressed and had poor physical health had four times greater odds of this outcome (OR = 3.99) by comparison with spouses/partners who had neither problem.

4.5.2 Couple relationship quality

When the predictive factors were individually modelled, two spouse/partner characteristics were statistically associated with relationship quality: not having a dependent child with one's ADF member, and mental and physical health problems (Table 4.11). Several ADF member characteristics were also related to spouses'/partners' perceptions of relationship quality: military status (Current Serving or Ex-Serving), rank, medical fitness for service, mental and physical health problems, problem drinking, and the number of lifetime traumas experienced.

In the joint model, many of these associations remained after adjusting for all factors, although some did not (ADF members' military status, medical fitness for service, number of lifetime traumas experienced). Additionally, spouses'/partners' level of education and ADF members' years of service in the ADF were now associated with relationship quality, although had not been when examined separately.

The findings regarding spouse/partner characteristics showed that:

- relationship quality was 0.13 points higher on average for spouses/partners who did not have dependent children with their ADF members compared to those who did
- compared to spouses who had university-level education, those with a certificate/diploma (beta = 0.17) or primary/secondary school education (beta = 0.18) tended to score higher on relationship quality
- spouses'/partners' mental and physical health problems were strongly associated with relationship quality, with spouses/partners scoring around half a point lower

if they were psychologically distressed (beta = -0.49), or psychologically distressed and had poor physical health (beta = -0.59), compared to those who had neither of these health issues.

There was some statistical evidence that ADF members' personal characteristics were associated with spouses'/partners' perceptions of relationship quality after taking other factors into account:

- Spouses/partners whose ADF members were psychologically distressed and had poor physical health scored on average -0.22 points lower on relationship quality than spouses with ADF members who did not have either problem.
- Spouses/partners whose ADF members were problem drinkers scored lower on relationship quality (beta = -0.16) than those whose ADF members were not problem drinkers.

Statistical evidence was found that two aspects of ADF members' military service were related to relationship quality as follows:

- Spouses/partners whose ADF members were Non-commissioned Officers scored on average -0.15 lower on relationship quality than the spouses/partners of Commissioned Officers.
- Relationship quality tended to increase by 0.01 points for each year served in the ADF.

4.5.3 Abuse in couple relationships

When examined separately, the only spouse/partner characteristic associated with abuse in couple relationships was the presence of mental and physical health problems. Several ADF member measures were separately associated with the occurrence of abuse: military status (Current Serving or Ex-Serving), years served, medical fitness for service, mental and physical health problems, and problem drinking (Table 4.12).

Table 4.10 FWS spouse/partner and ADF member predictors of an unhappy couple relationship

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.17*			0.33*			0.13*
18 – < 38 (reference)	1.00			1.00			1.00		
38 – < 48	1.47	(0.97 – 2.24)		1.33	(0.85 – 2.08)		1.54	(0.94 – 2.52)	
48+	1.38	(0.90 – 2.13)		1.36	(0.87 – 2.13)		1.74	(0.99 – 3.06)	
Does not have a child with ADF member	0.80	(0.51 – 1.25)	0.33	0.84	(0.52 – 1.35)	0.47	0.84	(0.52 – 1.37)	0.49
Education			0.93*			0.61*			0.37*
University degree (reference)	1.00			1.00			1.00		
Certificate/diploma	0.98	(0.67 – 1.44)		0.82	(0.55 – 1.22)		0.74	(0.49 – 1.12)	
Primary/secondary school	1.07	(0.68 – 1.68)		0.93	(0.57 – 1.51)		0.85	(0.51 – 1.40)	
Mental and physical health problems			< 0.0001*			< 0.0001*			< 0.0001*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	1.63	(0.88 – 3.04)		1.69	(0.90 – 3.18)		1.75	(0.92 – 3.33)	
High psychological distress	2.93	(1.78 – 4.83)		2.96	(1.78 – 4.93)		2.84	(1.68 – 4.80)	
Poor physical health and high psychological distress	4.10	(2.29 – 7.35)		4.21	(2.32 – 7.64)		3.99	(2.12 – 7.48)	
5+ people in household	0.95	(0.60 – 1.48)	0.81	0.93	(0.57 – 1.49)	0.75	0.94	(0.58 – 1.52)	0.79
Unemployed	1.01	(0.70 – 1.44)	0.97	0.92	(0.63 – 1.35)	0.67	0.94	(0.64 – 1.39)	0.76
Has served in the ADF	1.17	(0.77 – 1.80)	0.46	1.04	(0.66 – 1.63)	0.87	1.08	(0.68 – 1.72)	0.74
ADF MEMBER									
Ex-serving	1.26	(0.88 – 1.80)	0.20				1.07	(0.71 – 1.61)	0.74
Rank			0.23*						0.81*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	1.31	(0.93 – 1.86)					1.14	(0.77 – 1.69)	
Other rank	1.47	(0.76 – 2.83)					1.06	(0.47 – 2.35)	

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Service type			0.29*						0.57*
Army (reference)	1.00						1.00		
Navy	0.71	(0.45 – 1.13)					0.76	(0.46 – 1.26)	
Air Force	0.81	(0.55 – 1.18)					0.90	(0.59 – 1.37)	
Years served in the ADF	1.00	(0.98 – 1.02)	0.78				0.99	(0.96 – 1.01)	0.21
Never deployed	0.63	(0.33 – 1.19)	0.15				0.71	(0.36 – 1.41)	0.32
Medically unfit for service	1.46	(0.96 – 2.22)	0.07				1.15	(0.71 – 1.89)	0.57
Mental and physical health problems			0.03*						0.44*
Neither problem (reference)	1.00						1.00		
Poor physical health	1.23	(0.73 – 2.05)					0.92	(0.52 – 1.60)	
High psychological distress	1.03	(0.54 – 1.96)					0.84	(0.42 – 1.68)	
Poor physical health and high psychological distress	2.00	(1.26 – 3.15)					1.45	(0.83 – 2.54)	
Problem drinking	1.20	(0.81 – 1.76)	0.37				1.10	(0.71 – 1.69)	0.67
Number of traumas experienced	1.05	(0.99 – 1.11)	0.12				1.00	(0.94 – 1.07)	0.88

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

Table 4.11 FWS spouse/partner and ADF member predictors of relationship quality

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.29*			0.87*			0.15*
18 – < 38 (reference)	1.00			1.00			1.00		
38 – < 48	-0.09	(-0.21 to 0.03)		-0.03	(-0.16 to 0.09)		-0.11	(-0.24 to 0.03)	
48+	-0.02	(-0.14 to 0.11)		-0.01	(-0.13 to 0.11)		-0.15	(-0.30 to 0.01)	
Does not have a child with ADF member	0.14	(0.01 to 0.27)	0.04	0.13	(0.00 to 0.26)	0.05	0.13	(0.01 to 0.26)	0.04
Education			0.65*			0.14*			0.004*
University degree (reference)	1.00			1.00			1.00		
Certificate/diploma	0.04	(-0.07 to 0.15)		0.10	(-0.01 to 0.21)		0.17	(0.06 to 0.28)	
Primary/secondary school	0.06	(-0.08 to 0.19)		0.10	(-0.04 to 0.24)		0.18	(0.04 to 0.31)	
Mental and physical health problems			< 0.0001*			< 0.0001*			< 0.0001*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	-0.13	(-0.32 to 0.05)		-0.16	(-0.35 to 0.03)		-0.16	(-0.34 to 0.03)	
High psychological distress	-0.49	(-0.65 to -0.33)		-0.51	(-0.68 to -0.35)		-0.49	(-0.65 to -0.33)	
Poor physical health and high psychological distress	-0.71	(-0.90 to -0.51)		-0.72	(-0.92 to -0.52)		-0.59	(-0.79 to -0.39)	
5+ people in household	-0.02	(-0.16 to 0.11)	0.73	0.01	(-0.12 to 0.14)	0.88	-0.02	(-0.15 to 0.11)	0.78
Unemployed	0.01	(-0.10 to 0.12)	0.85	0.04	(-0.06 to 0.15)	0.42	0.02	(-0.08 to 0.13)	0.69
Has served in the ADF	-0.03	(-0.16 to 0.10)	0.67	0.01	(-0.12 to 0.14)	0.86	-0.04	(-0.16 to 0.09)	0.57
ADF MEMBER									
Ex-serving	-0.16	(-0.27 to -0.05)	0.003				-0.03	(-0.14 to 0.08)	0.61
Rank			< 0.0001*						0.01*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	-0.21	(-0.32 to -0.11)					-0.15	(-0.26 to -0.05)	
Other rank	-0.37	(-0.58 to -0.17)					-0.20	(-0.42 to 0.01)	

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.22*						0.39*
Army (reference)	1.00						1.00		
Navy	0.12	(-0.02 to 0.25)					0.03	(-0.10 to 0.16)	
Air Force	0.04	(-0.07 to 0.16)					-0.06	(-0.17 to 0.05)	
Years served in the ADF	0.00	(0.00 to 0.01)	0.10				0.01	(0.00 to 0.01)	0.05
Never deployed	0.18	(0.01 to 0.35)	0.04				0.13	(-0.04 to 0.29)	0.14
Medically unfit for service	-0.25	(-0.38 to -0.11)	0.0003				-0.09	(-0.23 to 0.05)	0.19
Mental and physical health problems			< 0.0001*						0.05*
Neither problem (reference)	1.00						1.00		
Poor physical health	-0.17	(-0.32 to -0.02)					-0.03	(-0.18 to 0.13)	
High psychological distress	-0.22	(-0.41 to -0.04)					-0.13	(-0.31 to 0.05)	
Poor physical health and high psychological distress	-0.44	(-0.58 to -0.29)					-0.22	(-0.38 to -0.05)	
Problem drinking	-0.22	(-0.34 to -0.10)	0.0003				-0.16	(-0.27 to -0.04)	0.01
Number of traumas experienced	-0.02	(-0.04 to -0.01)	0.010				-0.01	(-0.02 to 0.01)	0.46

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

Table 4.12 FWS spouse/partner and ADF member predictors of abuse in current couple relationships

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.85*			0.82*			0.13*
18 – < 38 (reference)	1.00			1.00			1.00		
38 – < 48	1.09	(0.48 – 2.48)		1.06	(0.45 – 2.53)		1.90	(0.71 – 5.09)	
48+	1.26	(0.56 – 2.82)		1.29	(0.55 – 2.99)		3.13	(1.03 – 9.49)	
Does not have a child with ADF member	1.00	(0.43 – 2.31)	1.00	1.03	(0.42 – 2.52)	0.95	1.00	(0.39 – 2.60)	1.00
Education			0.91*			0.38*			0.24*
University degree (reference)	1.00			1.00			1.00		
Certificate/diploma	0.85	(0.40 – 1.78)		0.60	(0.27 – 1.31)		0.49	(0.20 – 1.17)	
Primary/secondary school	0.91	(0.37 – 2.21)		0.63	(0.25 – 1.63)		0.56	(0.20 – 1.57)	
Mental and physical health problems			< 0.000*			< 0.0001*			0.0002*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	2.54	(0.82 – 7.80)		2.66	(0.85 – 8.36)		3.62	(1.09 – 12.01)	
High psychological distress	3.49	(1.40 – 8.70)		3.69	(1.45 – 9.41)		3.40	(1.24 – 9.34)	
Poor physical health and high psychological distress	8.51	(3.66 – 19.76)		8.76	(3.67 – 20.94)		8.89	(3.22 – 24.55)	
5+ people in household	0.72	(0.28 – 1.88)	0.50	0.75	(0.28 – 2.07)	0.58	0.84	(0.30 – 2.40)	0.75
Unemployed	1.81	(0.94 – 3.48)	0.08	1.60	(0.79 – 3.25)	0.19	1.78	(0.84 – 3.76)	0.13
Has served in the ADF	0.87	(0.36 – 2.13)	0.77	0.78	(0.30 – 1.98)	0.60	0.98	(0.36 – 2.68)	0.97
ADF MEMBER									
Ex-serving	2.93	(1.52 – 5.66)	0.001				1.98	(0.91 – 4.32)	0.09
Rank			0.06*						0.99*
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer	1.41	(0.69 – 2.88)					1.05	(0.45 – 2.47)	
Other rank	3.32	(1.22 – 9.05)					1.04	(0.26 – 4.21)	

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Service type			0.32*						0.72*
Army (reference)	1.00						1.00		
Navy	0.59	(0.23 – 1.47)					0.65	(0.22 – 1.89)	
Air Force	0.61	(0.29 – 1.32)					0.85	(0.35 – 2.05)	
Years served in the ADF	0.96	(0.93 – 1.00)	0.05				0.94	(0.90 – 0.99)	0.02
Never deployed	0.51	(0.12 – 2.15)	0.36				0.53	(0.11 – 2.50)	0.42
Medically unfit for service	2.34	(1.15 – 4.76)	0.02				1.09	(0.44 – 2.72)	0.86
Mental and physical health problems			0.0005*						0.12*
Neither problem (reference)	1.00						1.00		
Poor physical health	0.94	(0.27 – 3.27)					0.49	(0.12 – 1.95)	
High psychological distress	1.97	(0.64 – 6.05)					0.96	(0.27 – 3.46)	
Poor physical health and high psychological distress	4.62	(2.20 – 9.71)					2.35	(0.85 – 6.46)	
Problem drinking	2.28	(1.16 – 4.46)	0.02				1.80	(0.80 – 4.03)	0.15
Number of traumas	1.07	(0.97 – 1.18)	0.16				0.99	(0.86 – 1.14)	0.93

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

When examined jointly, only spouses'/partners' mental and physical health problems and ADF members' years of service remained associated with the occurrence of abuse:

- Spouses/partners who had poor physical health (OR = 3.62), were psychologically distressed (OR = 3.40), or were both psychologically distressed and had poor physical health (OR = 8.89), were associated with a higher risk of abuse in couple relationships by comparison with spouses/partners who did not have these health issues.
- More years served in the ADF were associated with a lower risk of abuse in couple relationships, with a one-year increase in service decreasing the odds of abuse by 6%.

4.6 Samples and variables used in the multivariate modelling of parenting practices

Of the 848 current spouses and partners for whom there were linked ADF member data, 686 (81%) had a child with their ADF member. Of these, 447 (65%) answered questions about a randomly selected child who was aged 2 to 17 years. Also, 96% of these parents had complete data for the demographic, background and military predictor variables and at least one parenting outcome variable, resulting in a final sample size of $n = 428$ for the multivariate modelling of parenting practices. The lower number available for these analyses than for previous analyses means that there is lower power to detect statistical associations. This can be particularly an issue if variables have a low occurrence. This constraint should be taken into account when reading these results.

Recoding of some predictor variables was necessary to avoid low numbers in some of the categories. Spouses'/partners' age and level of education were recoded into broader categories, ADF members who had left the ADF were combined into a single Ex-Serving category, and for rank, 'Non-commissioned Officer' and 'Other ranks' were combined. The characteristics of the analysis sample used to investigate predictors of parenting practices are summarised in Table 4.13.

Table 4.14 shows the means and standard deviations for the various parenting measures. Scores for all scales could range from 1 (indicating low levels of the particular parenting practice) to 5 (indicating high levels of the particular parenting practice). The means displayed in Table 4.14 are all towards the most effective ends of the scales, suggesting that parents were generally showing high levels of self-efficacy, consistency, reasoning and warmth, and low levels of hostility. Mean parenting scores for each categorical predictor variable are provided in Appendix I.

Table 4.13 FWS spouse/partner and ADF member characteristics (n = 428)

Measure	n	%
FWS RESPONDENT		
Spouse/partner age (years)		
18 – < 38	149	34.8
38 – < 48	216	50.5
48+	63	14.7
Child's age (years; mean, SD)	9.2	4.6
Education: below university degree	215	50.2
Mental and physical health problems		
Neither problem	330	77.1
Poor physical health	32	7.5
High psychological distress	39	9.1
Poor physical health and high psychological distress	27	6.3
5+ people in household	119	27.8
Unemployed	136	31.8
Has served in the ADF	80	18.7
ADF MEMBER		
Ex-serving	105	24.5
Rank: Non-commissioned Officer / Other	220	51.4
Service type		
Army	206	48.1
Navy	81	18.9
Air Force	141	32.9
Years served in the ADF (mean, SD)	18.4	8.0
Never deployed	42	9.8
Medically unfit for service	59	13.8
Mental and physical health problems		
Neither problem	294	68.7
Poor physical health	57	13.3
High psychological distress	28	6.5
Poor physical health and high psychological distress	49	11.4
Problem drinking	86	20.1
Number of traumas (mean, SD)	3.1	2.7

Note: Numbers and percentages shown unless otherwise stated. SD = standard deviation.

Table 4.14 Parenting practices outcomes (n = 428)

Measure	n	Mean	SD
Self-efficacy	428	4.0	0.9
Consistency	420	4.2	0.7
Hostility	422	1.9	0.6
Use of reasoning	420	4.2	0.7
Warmth	427	4.2	0.7

Note: SD = standard deviation.

4.7 Findings from the multivariate modelling of parenting practices

4.7.1 Parenting self-efficacy

When factors were individually modelled, spouses'/partners' mental and physical health problems, and ADF members' rank and deployment, were statistically associated with parenting self-efficacy (how well they thought they were going as parents) (Table 4.15).

In the joint model, spouses'/partners' mental and physical health problems and ADF members' deployment remained associated but rank did not. The findings showed that:

- spouses/partners who were psychologically distressed scored on average –0.33 lower on parenting self-efficacy, while spouses/partners with both poor physical health and psychological distress scored nearly half a point lower (beta = –0.47) than spouses/partners who did not have either health issue
- spouses/partners of ADF members who had never deployed scored –0.39 lower on parenting self-efficacy than those whose ADF members had been deployed.

Table 4.15 FWS spouse/partner and ADF member predictors of parenting self-efficacy

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.28*			0.33*			0.14*
18 – < 38 (reference)									
38 – < 48	0.01	(–0.17 to 0.20)		0.03	(–0.18 to 0.25)		0.01	(–0.22 to 0.24)	
48+	0.20	(–0.06 to 0.46)		0.22	(–0.10 to 0.53)		0.28	(–0.06 to 0.62)	
Child's age (years)	0.00	(–0.02 to 0.02)	0.91	–0.01	(–0.03 to 0.01)	0.49	–0.01	(–0.04 to 0.01)	0.31
Education									
University degree (reference)	1.00			1.00			1.00		
Below university degree	–0.03	(–0.20 to 0.14)	0.74	0.02	(–0.15 to 0.20)	0.78	0.06	(–0.12 to 0.25)	0.50
Mental and physical health problems			0.003*			0.008*			0.009*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	0.00	(–0.32 to 0.32)		0.02	(–0.31 to 0.35)		0.09	(–0.24 to 0.42)	
High psychological distress	–0.38	(–0.66 to –0.09)		–0.37	(–0.66 to –0.07)		–0.33	(–0.63 to –0.04)	
Poor physical health and high psychological distress	–0.50	(–0.84 to –0.16)		–0.47	(–0.82 to –0.12)		–0.47	(–0.83 to –0.11)	
5+ people in household	0.07	(–0.12 to 0.25)	0.49	0.06	(–0.13 to 0.25)	0.52	0.05	(–0.14 to 0.25)	0.57
Unemployed	–0.09	(–0.27 to 0.08)	0.30	–0.08	(–0.27 to 0.11)	0.41	–0.09	(–0.28 to 0.09)	0.33
Has served in the ADF	0.00	(–0.22 to 0.21)	0.97	0.02	(–0.20 to 0.24)	0.85	0.02	(–0.20 to 0.24)	0.87
ADF MEMBER									
Ex-serving	–0.04	(–0.23 to 0.16)	0.71				0.02	(–0.19 to 0.23)	0.87
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	–0.17	(–0.34 to 0.00)	0.05				–0.10	(–0.28 to 0.09)	0.31

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.49*						0.26*
Army (reference)	1.00						1.00		
Navy	-0.13	(-0.35 to 0.10)					-0.19	(-0.43 to 0.04)	
Air Force	-0.08	(-0.27 to 0.11)					-0.08	(-0.27 to 0.12)	
Years served in the ADF	0.005	(-0.005 to 0.016)	0.31				0.003	(-0.010 to 0.017)	0.62
Never deployed	-0.37	(-0.65 to -0.10)	0.009				-0.39	(-0.68 to -0.10)	0.008
Medically unfit for service	0.11	(-0.14 to 0.35)	0.39				0.24	(-0.03 to 0.51)	0.08
Mental and physical health problems			0.07*						0.06*
Neither problem (reference)	1.00						1.00		
Poor physical health	-0.20	(-0.45 to 0.05)					-0.20	(-0.46 to 0.06)	
High psychological distress	0.26	(-0.08 to 0.60)					0.32	(-0.03 to 0.67)	
Poor physical health and high psychological distress	-0.18	(-0.45 to 0.08)					-0.13	(-0.43 to 0.16)	
Problem drinking	-0.20	(-0.40 to 0.01)	0.07				-0.19	(-0.41 to 0.03)	0.09
Number of traumas	-0.01	(-0.04 to 0.02)	0.48				-0.03	(-0.06 to 0.00)	0.07

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

4.7.2 Parenting consistency

A number of child, parent and military service factors were associated with parenting consistency when examined separately (child age; spouses'/partners' educational levels, mental and physical health problems; and ADF members' Current Serving or Ex-Serving status, rank, and number of lifetime traumas experienced) (Table 4.16).

In the joint model, many of the individual effects were attenuated and only two factors remained statistically associated with parenting consistency: spouses'/partners' mental and physical health problems and ADF members' rank:

- Spouses/partners who were psychologically distressed, or had both poor physical health and psychological distress, scored around a third of a point lower on parenting consistency (betas = -0.29 and -0.31 respectively) than spouses/partners with neither health issue.
- Spouses/partners whose ADF member held the rank of Non-commissioned Officer/Other rank scored on average -0.15 points lower when compared to those whose ADF member was a Commissioned Officer.

Table 4.16 FWS spouse/partner and ADF member predictors of parenting consistency

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.85*			0.49*			0.49*
18 – < 38 (reference)									
38 – < 48	-0.01	(-0.15 to 0.13)		0.10	(-0.06 to 0.26)		0.10	(-0.07 to 0.28)	
48+	-0.06	(-0.25 to 0.14)		0.08	(-0.16 to 0.31)		0.08	(-0.18 to 0.33)	
Child's age (years)	-0.01	(-0.03 to 0.00)	0.04	-0.02	(-0.04 to 0.00)	0.04	-0.02	(-0.03 to 0.00)	0.06
Education									
University degree (reference)	1.00			1.00			1.00		
Below university degree	-0.12	(-0.25 to 0.00)	0.05	-0.07	(-0.20 to 0.06)	0.31	-0.01	(-0.15 to 0.13)	0.86
Mental and physical health problems			0.003*			0.009*			0.01*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	-0.16	(-0.40 to 0.08)		-0.17	(-0.42 to 0.07)		-0.16	(-0.41 to 0.09)	
High psychological distress	-0.31	(-0.52 to -0.09)		-0.29	(-0.51 to -0.07)		-0.29	(-0.50 to -0.07)	
Poor physical health and high psychological distress	-0.33	(-0.59 to -0.07)		-0.31	(-0.57 to -0.05)		-0.31	(-0.58 to -0.04)	
5+ people in household	0.09	(-0.04 to 0.23)	0.18	0.09	(-0.06 to 0.23)	0.24	0.08	(-0.06 to 0.23)	0.25
Unemployed	0.05	(-0.08 to 0.19)	0.44	0.08	(-0.06 to 0.22)	0.26	0.06	(-0.09 to 0.20)	0.44
Has served in the ADF	-0.08	(-0.24 to 0.08)	0.30	-0.02	(-0.19 to 0.14)	0.78	-0.03	(-0.19 to 0.14)	0.76
ADF MEMBER									
Ex-serving	-0.16	(-0.31 to -0.02)	0.03				-0.10	(-0.26 to 0.06)	0.22
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	-0.22	(-0.34 to -0.09)	0.0006				-0.15	(-0.29 to -0.01)	0.04

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.79*						0.65*
Army (reference)	1.00						1.00		
Navy	0.04	(-0.13 to 0.21)					0.04	(-0.13 to 0.21)	
Air Force	-0.03	(-0.17 to 0.12)					-0.04	(-0.19 to 0.10)	
Years served in the ADF	-0.001	(-0.009 to 0.007)	0.85				-0.003	(-0.013 to 0.007)	0.57
Never deployed	0.06	(-0.15 to 0.27)	0.58				0.08	(-0.13 to 0.30)	0.45
Medically unfit for service	-0.10	(-0.28 to 0.08)	0.29				0.06	(-0.15 to 0.26)	0.59
Mental and physical health problems			0.009*						0.08*
Neither problem (reference)	1.00						1.00		
Poor physical health	-0.15	(-0.33 to 0.04)					-0.03	(-0.23 to 0.16)	
High psychological distress	0.19	(-0.06 to 0.44)					0.29	(0.03 to 0.55)	
Poor physical health and high psychological distress	-0.26	(-0.46 to -0.06)					-0.11	(-0.33 to 0.12)	
Problem drinking	-0.19	(-0.35 to -0.03)	0.02				-0.14	(-0.31 to 0.03)	0.10
Number of traumas	-0.01	(-0.04 to 0.01)	0.27				-0.01	(-0.03 to 0.02)	0.67

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

4.7.3 Parenting hostility

The separate analyses showed that spouses'/partners' age and their physical and mental problems were strongly associated with parenting hostility (Table 4.17). There was also statistical evidence that ADF members' rank, years of service, and physical and mental health problems were associated with spouse's/partner's parenting hostility.

In the joint model, spouses'/partners' and ADF members' physical and mental health problems remained associated with parenting hostility, as did spouses'/partners' age. Children's age was also related to parental hostility in the multivariate model (although had not been in the univariate model). The main findings were:

- Spouses/partners aged 48 years and over scored on average a third of a point lower on hostility than their counterparts aged under 38 years of age (beta = -0.34).
- Spouses/partners who reported psychological distress and poor physical health scored nearly half a point higher on parenting hostility than parents with neither problem (beta = 0.43).
- The spouses/partners of psychologically distressed ADF members tended to be less hostile (beta = -0.38) than the spouses/partners of ADF members with neither problem.
- Spouses/partners with older children tended to be more hostile, with an increase of one year in children's age increasing the hostility score by 0.02 points.

Table 4.17 FWS spouse/partner and ADF member predictors of parenting hostility

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.007*			0.002*			0.004*
18 – < 38 (reference)									
38 – < 48	–0.05	(–0.16 to 0.07)		–0.10	(–0.23 to 0.03)		–0.08	(–0.22 to 0.06)	
48+	–0.26	(–0.42 to –0.10)		–0.35	(–0.54 to –0.15)		–0.34	(–0.55 to –0.13)	
Child's age (years)	0.00	(–0.01 to 0.01)	0.78	0.02	(0.00 to 0.03)	0.03	0.02	(0.00 to 0.03)	0.02
Education									
University degree (reference)	1.00		1.00			1.00			
Below university degree	0.02	(–0.08 to 0.13)	0.70	–0.02	(–0.12 to 0.09)	0.79	–0.04	(–0.15 to 0.08)	0.54
Mental and physical health problems			0.0009*			0.005*			0.002*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	0.05	(–0.15 to 0.25)		0.03	(–0.17 to 0.24)		0.01	(–0.20 to 0.22)	
High psychological distress	0.15	(–0.03 to 0.33)		0.14	(–0.04 to 0.32)		0.14	(–0.04 to 0.33)	
Poor physical health and high psychological distress	0.43	(0.21 to 0.65)		0.38	(0.16 to 0.60)		0.43	(0.20 to 0.65)	
5+ people in household	0.02	(–0.10 to 0.14)	0.72	0.01	(–0.10 to 0.13)	0.82	0.01	(–0.11 to 0.13)	0.88
Unemployed	0.09	(–0.02 to 0.20)	0.12	0.07	(–0.05 to 0.19)	0.24	0.09	(–0.03 to 0.20)	0.15
Has served in the ADF	0.01	(–0.12 to 0.15)	0.85	0.01	(–0.12 to 0.15)	0.85	0.01	(–0.12 to 0.15)	0.84
ADF MEMBER									
Ex-serving	0.07	(–0.05 to 0.19)	0.25				0.04	(–0.09 to 0.17)	0.52
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	0.11	(0.00 to 0.21)	0.05				0.04	(–0.08 to 0.16)	0.50

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.41*						0.48*
Army (reference)	1.00						1.00		
Navy	-0.04	(-0.18 to 0.10)					-0.02	(-0.16 to 0.13)	
Air Force	-0.08	(-0.20 to 0.04)					-0.07	(-0.20 to 0.05)	
Years served in the ADF	-0.007	(-0.013 to 0.000)	0.04				-0.003	(-0.011 to 0.006)	0.52
Never deployed	0.04	(-0.14 to 0.22)	0.65				0.04	(-0.14 to 0.22)	0.64
Medically unfit for service	0.03	(-0.13 to 0.18)	0.74				-0.02	(-0.19 to 0.15)	0.81
Mental and physical health problems			0.04*						0.003*
Neither problem (reference)	1.00						1.00		
Poor physical health	0.09	(-0.07 to 0.25)					0.07	(-0.09 to 0.24)	
High psychological distress	-0.24	(-0.45 to -0.03)					-0.38	(-0.60 to -0.16)	
Poor physical health and high psychological distress	0.09	(-0.08 to 0.26)					-0.04	(-0.23 to 0.15)	
Problem drinking	0.13	(0.00 to 0.27)	0.05				0.11	(-0.03 to 0.25)	0.12
Number of traumas	-0.01	(-0.02 to 0.01)	0.60				0.00	(-0.02 to 0.02)	0.95

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

4.7.4 Use of reasoning

When the predictive factors were individually modelled, child's age, and ADF member's rank, medical fitness for service, and physical and mental health problems, were found to be associated with the use of reasoning (Table 4.18).

However, in the joint model, only child's age remained statistically associated with the use of reasoning, reflecting greater use of reasoning when children were younger. None of the ADF member factors retained statistical significance.

Table 4.18 FWS spouse/partner and ADF member predictors of parenting use of reasoning

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.84*			0.51*			0.43*
18 – < 38 (reference)									
38 – < 48	-0.04	(-0.19 to 0.11)		0.07	(-0.10 to 0.25)		0.07	(-0.12 to 0.26)	
48+	-0.04	(-0.25 to 0.17)		0.15	(-0.11 to 0.40)		0.18	(-0.10 to 0.46)	
Child's age (years)	-0.02	(-0.03 to 0.00)	0.02	-0.02	(-0.04 to 0.00)	0.01	-0.02	(-0.04 to 0.00)	0.02
Education									
University degree (reference)	1.00			1.00			1.00		
Below university degree	-0.12	(-0.25 to 0.02)	0.09	-0.06	(-0.20 to 0.09)	0.44	-0.03	(-0.18 to 0.13)	0.74
Mental and physical health problems			0.08*			0.18*			0.30*
Neither problem (reference)									
Poor physical health	-0.17	(-0.43 to 0.09)		-0.14	(-0.41 to 0.12)		-0.12	(-0.38 to 0.15)	
High psychological distress	-0.29	(-0.52 to -0.05)		-0.25	(-0.49 to -0.01)		-0.21	(-0.45 to 0.03)	
Poor physical health and high psychological distress	-0.04	(-0.32 to 0.23)		0.01	(-0.27 to 0.30)		0.05	(-0.25 to 0.34)	
5+ people in household	0.02	(-0.13 to 0.17)	0.80	0.03	(-0.12 to 0.19)	0.66	0.03	(-0.13 to 0.18)	0.73
Unemployed	-0.06	(-0.21 to 0.08)	0.40	-0.07	(-0.23 to 0.08)	0.35	-0.10	(-0.25 to 0.05)	0.21
Has served in the ADF	-0.14	(-0.32 to 0.03)	0.10	-0.13	(-0.31 to 0.05)	0.14	-0.13	(-0.31 to 0.05)	0.15
ADF MEMBER									
Ex-serving	-0.14	(-0.29 to 0.02)	0.09				-0.09	(-0.26 to 0.09)	0.32
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	-0.14	(-0.28 to -0.01)	0.04				-0.06	(-0.21 to 0.09)	0.44

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.58*						0.78*
Army (reference)	1.00						1.00		
Navy	-0.03	(-0.21 to 0.15)					-0.06	(-0.25 to 0.13)	
Air Force	-0.08	(-0.24 to 0.07)					-0.05	(-0.21 to 0.11)	
Years served in the ADF	-0.001	(-0.010 to 0.007)	0.76				-0.004	(-0.014 to 0.007)	0.52
Never deployed	-0.20	(-0.43 to 0.02)	0.08				-0.22	(-0.45 to 0.02)	0.07
Medically unfit for service	-0.20	(-0.40 to 0.00)	0.05				-0.07	(-0.29 to 0.15)	0.55
Mental and physical health problems			0.005*						0.10*
Neither problem (reference)	1.00						1.00		
Poor physical health	-0.17	(-0.37 to 0.03)					-0.13	(-0.34 to 0.08)	
High psychological distress	0.17	(-0.10 to 0.44)					0.15	(-0.14 to 0.43)	
Poor physical health and high psychological distress	-0.33	(-0.54 to -0.11)					-0.23	(-0.48 to 0.01)	
Problem drinking	-0.10	(-0.27 to 0.07)	0.24				-0.06	(-0.24 to 0.12)	0.48
Number of traumas	-0.01	(-0.03 to 0.02)	0.64				0.00	(-0.03 to 0.02)	0.76

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

4.7.5 Parenting warmth

Several factors were individually related to parenting warmth – children’s age, a larger household size, whether spouses/partners had served in the ADF, and ADF members’ mental and physical health problems (Table 4.19).

All factors retained their association in the joint model, with spouses’/partners’ age also now significantly related to parenting warmth. The findings indicate that:

- parental warmth was lower among spouses/partners of older children, with an increase of one year being associated with decrease in parenting warmth of 0.07 points
- spouses/partners living in households with 5 or more people reported less warmth (beta = -0.18) than spouses/partners who lived in a household of 4 or fewer people
- spouses/partners who had served in the ADF tended to report less warmth (beta = -0.28) than civilian spouses/partners
- spouses/partners whose ADF members were psychologically distressed reported more warmth (beta = 0.38) than spouses/partners whose ADF members were not experiencing mental or physical health problems
- after adjustment, there was some evidence that spouse’/partners’ age was associated with greater warmth, with those aged 48 or more years reporting more warmth than those aged 18 to 37 years (beta = 0.39).

Table 4.19 FWS spouse/partner and ADF member predictors of parenting warmth

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.23*			0.005*			0.01*
18 – < 38 (reference)									
38 – < 48	-0.11	(-0.26 to 0.03)		0.19	(0.03 to 0.35)		0.15	(-0.02 to 0.32)	
48+	-0.14	(-0.35 to 0.07)		0.39	(0.15 to 0.62)		0.39	(0.14 to 0.64)	
Child's age (years)	-0.05	(-0.07 to -0.04)	< 0.0001	-0.07	(-0.08 to -0.05)	< 0.0001	-0.07	(-0.09 to -0.05)	< 0.0001
Education									
University degree (reference)	1.00			1.00			1.00		
Below university degree	0.05	(-0.08 to 0.19)	0.45	0.09	(-0.04 to 0.22)	0.19	0.09	(-0.04 to 0.23)	0.18
Mental and physical health problems			0.37*			0.57*			0.49*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	0.08	(-0.18 to 0.33)		0.02	(-0.22 to 0.27)		0.04	(-0.21 to 0.28)	
High psychological distress	-0.10	(-0.33 to 0.14)		-0.06	(-0.28 to 0.15)		-0.03	(-0.25 to 0.18)	
Poor physical health and high psychological distress	-0.20	(-0.48 to 0.07)		-0.17	(-0.43 to 0.09)		-0.20	(-0.46 to 0.07)	
5+ people in household	-0.25	(-0.40 to -0.10)	0.001	-0.19	(-0.33 to -0.05)	0.008	-0.18	(-0.32 to -0.04)	0.01
Unemployed	0.03	(-0.11 to 0.17)	0.68	-0.04	(-0.18 to 0.10)	0.59	-0.05	(-0.19 to 0.09)	0.51
Has served in the ADF	-0.32	(-0.49 to -0.15)	0.0003	-0.31	(-0.47 to -0.15)	0.0002	-0.28	(-0.44 to -0.12)	0.0008
ADF MEMBER									
Ex-serving	-0.09	(-0.25 to 0.06)	0.23				-0.08	(-0.24 to 0.07)	0.29
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	0.02	(-0.11 to 0.16)	0.76				0.06	(-0.08 to 0.20)	0.37

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value	Beta	(95% CI)	p-value
Service type			0.27*						0.33*
Army (reference)	1.00						1.00		
Navy	-0.07	(-0.25 to 0.11)					-0.12	(-0.29 to 0.06)	
Air Force	-0.12	(-0.28 to 0.03)					-0.08	(-0.23 to 0.06)	
Years served in the ADF	-0.004	(-0.012 to 0.005)	0.39				0.007	(-0.003 to 0.017)	0.16
Never deployed	-0.14	(-0.37 to 0.09)	0.22				-0.15	(-0.36 to 0.07)	0.18
Medically unfit for service	-0.03	(-0.23 to 0.16)	0.75				0.06	(-0.14 to 0.26)	0.54
Mental and physical health problems			0.0007*						0.0008*
Neither problem (reference)	1.00						1.00		
Poor physical health	-0.14	(-0.34 to 0.06)					-0.18	(-0.37 to 0.02)	
High psychological distress	0.40	(0.13 to 0.67)					0.38	(0.12 to 0.64)	
Poor physical health and high psychological distress	-0.25	(-0.46 to -0.03)					-0.21	(-0.43 to 0.01)	
Problem drinking	0.02	(-0.15 to 0.19)	0.84				0.00	(-0.17 to 0.16)	0.96
Number of traumas	0.00	(-0.02 to 0.03)	0.84				-0.01	(-0.03 to 0.02)	0.53

* Joint test of significance.

Note: 95% CI = 95% confidence interval.

4.8 Samples and variables used in the multivariate modelling of child total behaviour problems

Of the 848 current spouses and partners who had linked ADF member data, 686 (81%) had a child with the ADF member. Of these, 447 (65%) answered questions about a randomly selected child who was aged 2 to 17 years. Around 94% of these spouses/partners had complete data for the demographic, background, parenting and military predictor variables and the child total behaviour problems outcome, resulting in a sample size of $n = 420$ for these analyses. Again, the lower number available for these analyses and consequent lower power to detect statistical associations should be taken into account when reading these analyses.

For the modelling, recoding of some predictor variables was necessary to avoid low numbers in some of the categories. Spouses'/partners' age and level of education were recoded into broader categories, ADF members who had left the ADF were combined into a single Ex-Serving category, while for rank, the 'Non-commissioned Officer' and 'Other rank' categories were combined. The characteristics of the analysis sample used to investigate predictors of child behaviour problems are summarised in Table 4.20.

Table 4.20 FWS spouse/partner and ADF member characteristics (n = 420)

Measure	n	%
FWS SPOUSE/PARTNER		
Parent's age (years)		
18 – < 38	147	35.0
38 – <48	211	50.2
48+	62	14.8
Child's age (years; mean, SD)	9.1	4.6
Education: below university degree	210	50.0
Mental and physical wellbeing		
Neither problem	324	77.1
Poor physical health	31	7.4
High psychological distress	39	9.3
Poor physical health and high psychological distress	26	6.2
5+ people in household	118	28.1
Unemployed	131	31.2
ADF member	79	18.8
Parenting consistency (mean, SD)	4.2	0.7
Parenting hostility (mean, SD)	1.9	0.5
ADF MEMBER		
Ex-serving	103	24.5
Rank: Non-commissioned Officer / Other	216	51.4
Service		
Navy	81	19.3
Army	202	48.1
Air Force	137	32.6
Years served in ADF (mean, SD)	18.4	8.0
Never deployed	42	10.0
Medically unfit for service	58	13.8
Mental and physical wellbeing		
Neither problem	289	68.8
Poor physical health	55	13.1
High psychological distress	28	6.7
Poor physical health and high psychological distress	48	11.4
Problem drinking	83	19.8
Number of traumas (mean, SD)	3.1	2.7

Note: Numbers and percentages shown unless otherwise stated. SD = standard deviation.
The prevalence of child behaviour problems in this analysis sample was 11.0%.

4.9 Findings from the multivariate modelling of child total behaviour problems

When looked at separately, child age, spouses'/partners' physical and mental health problems, and their levels of parenting consistency and hostility were found to be associated with high levels of child behaviour problems (Table 4.21). No ADF member personal characteristic or military service-related factor was statistically associated with child behaviour problems in the separate analyses.

When looked at jointly, the associations remained for parenting hostility and spouses'/partners' mental and physical health problems, as follows:

- Spouses'/partners' parenting hostility was strongly associated with an increased risk of behaviour problems, with a one-point increase in the hostility score increasing the odds by a factor of 11.50.
- All types of mental and physical health problems in spouses/partners were risks for child behaviour problems. Children of spouses/partners with physical health problems had a five-fold increase in their odds of behaviour problems (OR = 5.01); children of spouses/partners who were psychologically distressed had a three-fold increase in odds (OR = 3.68); while children of spouses/partners who had both poor physical health and psychological distress were 11 times more likely to have behaviour problems (OR = 11.01) than children of spouses/partners who did not have these problems.
- After adjustment, there was some evidence that ADF members' problem drinking was associated with a higher risk of child behaviour problems (OR = 3.03).

Table 4.21 FWS spouse/partner and ADF member predictors of child total behaviour problems

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
FWS SPOUSE/PARTNER									
Age (years)			0.32*			0.38*			0.25*
18 – < 38 (reference)	1.00			1.00			1.00		
38 – < 48	1.57	(0.78 – 3.14)		2.05	(0.74 – 5.69)		2.71	(0.83 – 8.89)	
48+	0.90	(0.31 – 2.63)		1.83	(0.39 – 8.57)		2.20	(0.38 – 12.81)	
Child's age (years)	1.07	(1.00 – 1.15)	0.05	1.06	(0.95 – 1.18)	0.27	1.05	(0.94 – 1.17)	0.38
Education									
University degree (reference)	1.00			1.00			1.00		
Below university degree	1.22	(0.66 – 2.26)	0.52	0.60	(0.26 – 1.35)	0.22	0.59	(0.23 – 1.48)	0.26
Mental and physical health problems			< 0.0001*			< 0.0001*			0.0005*
Neither problem (reference)	1.00			1.00			1.00		
Poor physical health	3.64	(1.34 – 9.88)		5.83	(1.72 – 19.78)		5.01	(1.37 – 18.35)	
High psychological distress	3.91	(1.59 – 9.61)		3.57	(1.20 – 10.65)		3.68	(1.14 – 11.82)	
Poor physical health and high psychological distress	12.99	(5.31 – 31.75)		11.71	(3.83 – 35.86)		11.01	(3.18 – 38.13)	
5+ people in household	0.89	(0.44 – 1.78)	0.74	0.94	(0.39 – 2.24)	0.89	1.01	(0.40 – 2.51)	0.99
Unemployed	1.21	(0.64 – 2.31)	0.56	1.12	(0.49 – 2.54)	0.79	1.11	(0.47 – 2.64)	0.81
Has served in the ADF	1.83	(0.91 – 3.67)	0.09	1.60	(0.67 – 3.81)	0.29	1.85	(0.72 – 4.76)	0.20
Parenting consistency	0.33	(0.21 – 0.50)	< 0.0001	0.70	(0.40 – 1.22)	0.21	0.72	(0.39 – 1.30)	0.27
Parenting hostility	9.88	(5.16 – 18.90)	< 0.0001	8.62	(3.93 – 18.93)	< 0.0001	11.50	(4.65 – 28.47)	< 0.0001
ADF MEMBER									
Ex-serving	0.96	(0.47 – 1.97)	0.91				0.42	(0.14 – 1.27)	0.12
Rank									
Commissioned Officer (reference)	1.00						1.00		
Non-commissioned Officer / Other rank	1.55	(0.83 – 2.89)	0.17				0.81	(0.32 – 2.02)	0.65

Measure	All measures fitted separately			FWS respondent measures fitted jointly			All measures fitted jointly		
	OR	(95% CI)	p-value	OR	(95% CI)	p-value	OR	(95% CI)	p-value
Service type			0.62*						0.26*
Army (reference)	1.00						1.00		
Navy	1.01	(0.43 – 2.40)					1.35	(0.43 – 4.25)	
Air Force	1.38	(0.70 – 2.71)					2.24	(0.84 – 5.94)	
Years served in the ADF	1.00	(0.97 – 1.04)	0.82				0.99	(0.93 – 1.06)	0.80
Never deployed	1.40	(0.56 – 3.54)	0.47				1.13	(0.31 – 4.05)	0.85
Medically unfit for service	0.75	(0.28 – 1.99)	0.57				0.94	(0.25 – 3.60)	0.93
Mental and physical health problems			0.40*						0.65*
Neither problem (reference)	1.00						1.00		
Poor physical health	1.89	(0.84 – 4.28)					1.68	(–0.4 – 3.04)	
High psychological distress	1.16	(0.33 – 4.10)					2.12	(0.33 – 13.61)	
Poor physical health and high psychological distress	1.65	(–0.02 – 5.02)					0.80	(0.17 – 3.80)	
Problem drinking	1.93	(0.98 – 3.81)	0.06				3.03	(1.01 – 9.08)	0.05
Number of traumas	0.93	(0.81 – 1.06)	0.28				0.90	(0.74 – 1.09)	0.28

* Joint test of significance.

Note: 95% CI = 95% confidence interval. OR = odds ratio.

4.10 Summary

Chapter 4 aimed to investigate the FWS participant and ADF member characteristics and military-related factors that were significantly associated with outcomes after the effects of other variables were taken into account. We next bring together the findings from the jointly fitted multivariate models to aid identification of the factors that were associated with several outcomes. It should be noted that samples sizes were considerably larger for analyses of all FWS family members and spouses/partners than for the subgroups who reported on parenting practices and child behaviour problems. The lower power for the latter analyses suggests some caution should be used in interpreting their findings, as the smaller sample sizes may have limited the study's capacity to detect significant differences to some extent.

Table 4.22 summarises the FWS respondent and ADF member demographic, personal functioning, and military service factors found to be associated with FWS family members' psychological distress, PTSD, and problem drinking.

Table 4.22 Summary of factors associated with family members' mental health outcomes and problem drinking

Measure	Psychological distress	PTSD	Problem drinking
FWS RESPONDENT*			
Relationship to ADF member (reference: spouse/partner)	↑ Adult children		↑ Adult children
Education			
Poor physical health	↑	↑	↑
5+ people in household			
Unemployed			
Has served in the ADF	↑	↑	
ADF MEMBER			
Military status (reference: Current Serving)			
Rank (reference: Commissioned Officer)	↑ Other rank		
Service type (reference: Army)		↑ Navy	
Years served in the ADF		↓	
Never deployed			
Medical fitness for service			
Mental and physical health problems			
Problem drinking			↑
Number of traumas			

* All measures in this subsection relate to the FWS respondent unless stated otherwise.

↑ = This factor increased the risk of the outcome.

↓ = This factor decreased the risk of the outcome.

Table 4.22 shows that several factors were associated with more than one mental health or problem drinking outcome:

- Adult children were at greater risk of psychological distress and problem drinking than spouses/partners.
- FWS respondents' poor physical health was a risk for all three problematic outcomes.
- FWS respondents who had served in the ADF had a higher risk of psychological distress and PTSD than civilian FWS respondents.

Some factors were associated with only one mental health outcome or problem drinking:

- FWS respondents whose ADF members held an 'Other rank' had a higher risk of psychological distress than FWS respondents whose ADF members were Commissioned Officers.
- FWS respondents whose ADF members were in the Navy were at greater risk of PTSD than FWS respondents whose ADF members were in the Army.
- The risk of PTSD among FWS respondents decreased with increasing length of ADF members' service.
- FWS respondents whose ADF members reported risky drinking were at greater risk of problem drinking themselves.

Table 4.23 summarises the FWS spouse/partner and ADF member demographic, personal functioning, and military service factors found to be associated with an unhappy couple relationship, relationship quality, and abuse in couple relationships.

Table 4.23 Summary of factors associated with couple relationship outcomes

Measure	Unhappy couple relationship	Couple relationship quality	Abuse in couple relationship
FWS RESPONDENT*			
Age			
Does not have a child with ADF member		↑	
Education (reference: university degree)		↑ Certificate/diploma ↑ Primary/secondary school	
Mental and physical wellbeing (reference: neither problem)	↑ Psychological distress ↑ Both problems	↓ Psychological distress ↓ Both problems	↑ Poor physical health ↑ Psychological distress ↑ Both problems
5+ people in household			
Unemployed			
Has served in the ADF			
ADF MEMBER			
Military status (reference: Current Serving)			
Rank (reference: Commissioned Officer)		↓ Non-commissioned Officer rank	
Service type (reference: Army)			
Years served in the ADF		↑	↓
Never deployed			
Medically unfit for service			
Mental and physical health problems (reference: neither problem)		↓ Both problems	
Problem drinking		↓	
Number of traumas			

* All measures in this subsection relate to the FWS respondent unless stated otherwise.

↑ = This factor increased the risk/level of the outcome.

↓ = This factor decreased the risk/level of the outcome.

Factors associated with characteristics of couple relationships were as follows:

- Respondents' psychological distress, either alone or when accompanied by poor physical health, was associated with a higher risk of relationship unhappiness, poor relationship quality, and higher rates of abuse in couple relationships.
- A longer length of ADF members' service was related to increased levels of relationship happiness and lower rates of abuse in couple relationships.
- ADF members' psychological distress and poor physical health were associated with lower couple relationship quality by comparison with those who did not have either health issue.
- Problem drinking among ADF members was associated with lower couple relationship quality.

- Couple relationship quality tended to be lower in families with Non-commissioned Officers when compared to families where ADF members held a Commissioned Officer rank.
- Couple relationship quality tended to be higher among couples who did not have children together.
- Couple relationship quality tended to be higher if spouses'/partners' highest education level was a certificate/diploma or primary/secondary schooling compared to those with a university degree.

Table 4.24 summarises the factors that were related to spouses'/partners' parenting practices on the dimensions of self-efficacy, consistency, hostility, use of reasoning, and warmth.

Factors that were related to parenting dimensions were as follows:

- Spouses'/partners' age – older parents tended to use less hostility and more warmth in their interactions with their children than younger parents.
- Children's age – if children were older, spouses/partners were more likely to report hostility and less likely to report the use of reasoning or show warmth when interacting with their children.
- Spouses/partners with poor physical health and psychological distress reported lower levels of parenting self-efficacy and consistency, and higher levels of hostility, than those with neither of these health issues. Spouses/partners with only psychological distress also reported lower levels of self-efficacy and consistency.
- Spouses/partners whose ADF members reported psychological distress tended to use less hostility and more warmth when parenting their children than spouses/partners whose ADF members had no health issues.
- Spouses/partners who had served in the ADF tended to report lower warmth when parenting children compared to civilian spouses/partners.
- Spouses/partners of Non-commissioned Officers tended to report less consistency when parenting than spouses/partners of Commissioned Officers.
- A larger family size was associated with less warmth compared with a smaller household size.

- Spouses/partners of ADF members who had never been deployed tended to report lower parenting self-efficacy than spouses/partners whose ADF members had been deployed.

Three factors were related to total behaviour problems in children aged 2 to 17 years after accounting for the effects of other variables:

- Spouses'/partners' psychological distress, either alone or when accompanied by poor physical health, was associated with a higher risk of behaviour problems.
- Higher levels of parenting hostility were associated with a greater risk of behaviour problems.
- Children whose ADF members were Ex-Serving had a reduced risk of behaviour problems.

Finally, we present in Table 4.25 the factors associated with at least one indicator in multiple outcome areas – FWS participants' *personal wellbeing* (psychological distress, PTSD, or problem drinking); *couple relationships* (unhappiness, relationship quality, or abuse); *parenting practices* (self-efficacy, consistency, hostility, use of reasoning, or warmth); and *child behaviour problems*. If a factor was only included in the analyses for one outcome area, it is not shown in Table 4.25 (e.g. how FWS participants were related to ADF members was only included in the area *personal wellbeing*, so is not shown in Table 4.25).

Five factors were found to be significantly associated with outcomes across more than one broad outcome area:

- FWS respondents' physical and mental health – all four broad areas
- ADF members' physical and mental health – three broad areas (FWS respondents' personal wellbeing, couple relationships, parenting practices)
- ADF members holding more junior service ranks – three broad areas (FWS respondents' personal wellbeing, couple relationships, parenting practices)
- FWS respondents having served in the ADF – two broad areas (FWS respondents' personal wellbeing and parenting practices)
- ADF members' problem drinking – two broad areas (FWS respondents' personal wellbeing and couple relationships).

Table 4.24 Summary of factors associated with spouses'/partners' parenting of children aged 2 to 17 years

Measure	High self-efficacy	High consistency	High hostility	High use of reasoning	High warmth
FWS RESPONDENT*					
Age (reference: 18 – < 38 years)			↓ Aged 48+ years		↑ Aged 48+ years
Child's age			↑	↓	↓
Education					
Mental and physical health problems (reference: neither problem)	↓ Psychological distress ↓ Both problems	↓ Psychological distress ↓ Both problems	↑ Both problems		
5+ people in household					↓
Unemployed					
Has served in the ADF					↓
ADF MEMBER					
Military status (reference: Current Serving)					
Non-commissioned Officer / Other rank (reference: Commissioned Officer)		↓			
Service type (reference: Army)					
Years served in the ADF					
Never deployed	↓				
Medically unfit for service					
Mental and physical health problems (reference: neither problem)			↓ Psychological distress		↑ Psychological distress
Problem drinking					
Number of traumas					

* All measures in this subsection relate to the FWS respondent unless stated otherwise.

↑ = This factor increased the level of the outcome.

↓ = This factor decreased the level of the outcome.

Table 4.25 Summary of factors found to be significant predictors of one or more indicators used to assess the major areas examined

Measure	Personal wellbeing	Couple relationships	Parenting practices	Child behaviour problems
FWS RESPONDENT*				
Age (reference: 18 – < 38 years)	–			
Child's age	–	–	*	
Education		*		
Mental and physical health problems (reference: neither problem)	[*]	*	*	*
5+ people in household			*	
Unemployed				
Has served in the ADF	*		*	
ADF MEMBER				
Military status (reference: Current Serving)				*
Non-commissioned Officer / Other rank (reference: Commissioned Officer)	*	*	*	
Service type (reference: Army)	*			
Years served in the ADF	*			
Never deployed			*	
Medically unfit for service				
Mental and physical health problems (reference: neither problem)	[*]	*	*	
Problem drinking	*	*		
Number of traumas				

* All measures in this subsection relate to the respondent unless stated otherwise.

* The factor was significantly associated with one or more outcomes in this area.

[*] Physical health only was examined for this outcome area.

Note: A dash (–) indicates 'not examined for this area'.

5 Discussion

Part 1, the quantitative component of the Family Wellbeing Study (FWS), addresses five main questions:

- What is the overall health and wellbeing of Australian military families (e.g. their mental health, physical health, couple relationships, family financial wellbeing)?
- Do families of current serving and ex-serving ADF members differ on physical, psychosocial and material wellbeing? Do they experience similar or unique problems?
- What is the perceived effect of military service on families?
- What are the help-seeking needs of military families? Do needs differ for families of current serving and ex-serving ADF members?
- What impact do ADF members' service characteristics and physical and mental health have on the health and wellbeing of family members after taking into account the influence of other salient factors?

For the first question, findings on health and wellbeing were reported overall for all FWS participants; and separately for spouses/partners, parents and adult children. Potential influential factors were examined one by one to gauge their independent effect. For spouses/partners, a wide range of aspects were investigated, including mental and physical health, risk-taking, finances, mobility, couple relationships, parenting, child behaviour, help-seeking behaviours, and the impact of ADF members' military service on various aspects of spouses'/partners' lives. For the parents and adult children of ADF members, the focus was on family members' mental and physical health, risk-taking, and the impact of the ADF members' military lifestyle on their relationships and lives.

For the second question, family members of current serving and ex-serving ADF members were compared on all these characteristics to determine the nature and extent of significant differences.

For the third question, all FWS participants were asked whether they had been concerned about their own mental health and if so, for how long; whether they had sought help; the types of problems that had led them to seek help; and where they had obtained help. If they had not sought help, respondents were asked why they had not and whether there had been barriers that hindered their help seeking. From this

information, a picture of the degree to which FWS participants had unmet service needs could be obtained and the possibility that needs were higher following the transition from military service could be investigated.

For the fourth question, it was possible to include only family members whose ADF members had agreed to link their data. Therefore, a slightly smaller sample of FWS participants was used. To investigate family members' mental health, a modelling framework was used to estimate associations between military service factors and mental health outcomes while taking into account FWS participants' and ADF members' demographic and background characteristics and levels of physical health. For couple relationship outcomes, the same analysis approach and measures were used, with measures of FWS participants' mental health and risk-taking also included. The influence of military service on parenting practices and children's behaviour was investigated only for spouses/partners who had a child aged 2 to 17 years. The same variables included in the analyses of couple relationships were used (and measures of parenting practices were also included in analyses of children's behaviour).

These findings are now brought together in Chapter 5 of Part 1. Findings for the whole FWS sample are discussed, then differences between family members of Current Serving and Ex-Serving ADF members, the effect of military service on family members' physical, psychosocial and material wellbeing, and the implications of the findings. Where possible, comparisons to the general Australian population are provided to evaluate how members of military families are faring.

Some constraints arising from the sample recruited are first noted.

5.1 Representativeness of the FWS sample

It was not possible to investigate how representative the family members participating in the FWS were compared to the population of ADF families, as information about all ADF families is not available. Even if it were possible to access information on ADF members' immediate families, the ADF members participating in the Mental Health and Wellbeing Transition Study (MHWTS) were not restricted in who they could nominate. They could, for example, nominate a parent figure or someone who was not their partner, parent or adult child (e.g. a sibling or a cousin). In short, it was not possible to evaluate how representative the families who participated in the FWS were relative to the general population of ADF military families due to a lack of available data and the diversity of family members nominated.

However, it was possible to examine how representative the ADF members whose family members participated in the FWS were compared to the large sample contained in the Military and Veteran Research Study Roll (Programme population; $n = 77,432$) on a limited number of measures.

Compared to the Programme population:

- ADF members whose family members participated in the FWS tended to be older
- females were over-represented in the Current Serving ADF member subsample with a participating FWS family member, but not in the Ex-Serving subsample
- Commissioned Officers were over-represented in both the current and Ex-Serving ADF member subsamples with participating family members. Those with the rank of 'other' were under-represented
- the Air Force was over-represented in the current and Ex-Serving ADF member subsamples with FWS participants and the Army was under-represented; additionally, the Navy was under-represented in the Current Serving subsample
- levels of fitness for military service were similar and not significantly different when comparing Current Serving and Ex-Serving ADF members with participating FWS family members to the Programme population.

The over-representation of older, female, higher ranking, and Air Force ADF members in the MHWTS responding sample whose family members took part in the FWS may have introduced some level of bias, as these characteristics could be expected to independently contribute to the findings. This bias indicates caution is needed in generalising to the broader ADF military family population.

We also compared MHWTS respondents whose family members took part in the FWS to MHWTS respondents whose family members did not take part. These comparisons revealed that the FWS sample was somewhat biased towards families in which serving members held higher ranks, were more highly educated, and were older (for Current Serving and Ex-Serving subgroups alike). Thus, the FWS findings are likely to be particularly relevant to families whose serving members have these characteristics, but may be less pertinent to families in which serving members hold more junior ranks, are younger or less educated. Again, these limitations are likely to affect the generalisability of the FWS findings.

However, it is important to note that there were generally no significant differences on indicators of mental health and risk-taking when comparing ADF members whose family members took part in the FWS and those whose family members did not take part (derived from the MHWTS dataset). Thus, there was not a systematic trend for the ADF members of the families participating in the FWS to be better (or more poorly) adjusted or to differ in their propensity for risk-taking, suggesting that FWS families are relatively representative in terms of their ADF members' psychosocial health and wellbeing.

In summary, there appears to be a certain amount of bias in the demographic and service-related characteristics of ADF members with FWS data, as these ADF members tended to be older, more highly educated, contain a higher proportion of females, and hold more senior ranks than the Programme population from which they were derived. If these characteristics are associated with better functioning, which then affects military families, then FWS findings may provide a more positive picture than might have been found using a more representative sample. Thus, the generalisability of the FWS findings may be affected to some extent. These constraints should be borne in mind when considering the FWS findings and their implications.

5.2 What is the overall health and wellbeing of Australian military families?

The next sections discuss findings relevant to the first question on how FWS military families were faring by comparison with other studies of military populations and the general Australian population.

Comparison to Australian population data is complex due to the diverse nature of the FWS cohort. Not only did the FWS cohort mostly comprise females (85%), but it also tended to comprise more highly educated persons, and covered a wide range of ages. Thus, comparable general population data would need to simultaneously take into account trends for males or females and individuals of differing ages and levels of education, and we have not been able to locate such detailed information. We therefore focus on data for females, further subdivided for different age groups if data are available. Otherwise, our comparisons are to the total population of Australian females, or the general Australian population, depending on the data available.

5.2.1 Residential and school mobility

One of the most frequently highlighted difficulties for military families is the high number of residential relocations caused by military service. These have been shown to have many negative consequences, including disruptions to parental employment/careers and children's schooling, loss of parental and child social networks, and physical separation from significant family members (Drummet et al., 2003; Park, 2011; Sheppard et al., 2010). Frequent relocations can cause emotional distress and put pressure on individual and family wellbeing (although can also provide new opportunities, e.g. the expansion of social networks). We next compare rates of residential and school moves made by FWS military families and children to other studies of military families and to the Australian general community.

Looking first at the number of places FWS families had lived in during ADF members' military service, this was most commonly 3 to 4 places (30.3% of families), followed by 5 to 6 places (21.5% of families). However, residential moves could have been made for a variety of reasons and not necessarily military-related. When asked about the

number of moves made as a direct result of ADF members' military service, only 15.3% had never moved, 22.1% had moved 1 to 2 times, and 62.6% had moved three or more times. These prevalence levels are similar to those found in the 2012 ADF Families Survey (Atkins et al., 2014), where 10% had never moved because of a family member's military service and the average number of moves made as a result of military relocation was four.

The available comparable Australian general population comes from the Australian Bureau of Statistics (ABS) 2007–08 Survey of Income and Housing (Australian Bureau of Statistics, 2010). A total of 27% of the ABS sample had been living in their current home for 15 or more years, 30% had been there for between 5 and 14 years, and 43% had moved one or more times in the previous five years. Among the latter group, 46% had moved once, 19% had moved twice and 36% had move three or more times. While the data differ somewhat, this comparison makes clear that Australian military families move considerably more often than civilian families.

FWS participants were also asked how many school moves children had made during ADF members' military service. Of the children who were school age, 49.4% were in the primary school age range and 50.6% were in the secondary school age range. The number of schools attended ranged from one to six – 37.5% had attended four or more, followed by 19.8% who had attended three schools. However, it should be noted that this figure could have included moves that are generally expected, such as that from primary to secondary school, and is influenced by children's age (older children have had a longer time in which a school move could have occurred), and does not cover the totality of children's school careers from start to finish.

We have not located comparable data for Australian military families, but US data show that on average, children in military families move school three times more often than their civilian counterparts (Bradshaw, Sudinharaset, Mmari, & Blum, 2010), and typically change schools between six and nine times from the start of elementary school to the end of secondary school (Astor, 2011).

The Australian population data located on children's school mobility do not provide information on the total number of school moves made over the course of children's school careers. However, New South Wales Department of Education data from 2008 to 2014 spanning the period from the start of the kindergarten (prep) year to the end of grade six showed that 69% of children did not move school during this time, 20% moved once, 7% moved twice and 5% moved three or more times (Lu & Rickard, 2014). Looking next at secondary school students, 77% did not move schools between years 7 and 12, 15% moved once, 5% moved twice and 3% moved three or more times (Lu & Rickard, 2014). While the FWS and general New South Wales population data differ, it seems fair to conclude that school mobility tends to be higher among Australian

children in military than civilian families, although it is not possible to quantify by how much. In recognition of the difficulties that children in military families often experience when moving school for military reasons, the Australian Government Department of Defence provides a range of services and resources to assist children and families. Through these policies and services, the Australian Government endeavours to alleviate the effects of residential transitions on children and families.

Summing up, the FWS findings on family and school relocations are consistent with other Australian and international studies of military families in showing that FWS families frequently experienced residential and school moves. These rates were higher than in the general Australian population. Relocations are an unavoidable part of the military family lifestyle, with their amount and frequency a known source of stress that can place strain on individual and family wellbeing, employment and careers, and social networks (Drummet et al., 2003; Park, 2011; Sheppard et al., 2010). While the FWS did not collect data on the effect of military-related relocations on FWS families, their frequent occurrence has likely been a source of vulnerability for the military families participating in the FWS.

5.2.2 Economic wellbeing

Financial wellbeing

Previous US research indicates that most military families do not experience financial pressure (Hosek & Wadsworth, 2013). However, a minority struggle financially; for example, in 2010, one-quarter of US military families had experienced difficulties with paying bills, writing cheques that bounced, missing credit card payments, falling behind on rent or mortgage payments, or being pursued by debt collectors for unpaid bills (Hosek & Wadsworth, 2013). We could not locate similar data for Australian military families.

The FWS sought information from spouses/partners on whether similar problems had been experienced because of a shortage of money. The most frequent financial hardships experienced were increased credit card or bank debt (24.3%), followed by not being able to pay electricity, gas or telephone bills on time (16.1%) and needing to seek financial help from families or friends (15.1%). These rates are consistent with the US results described above, although the comparison should be viewed cautiously due to differences in the economic conditions and regulatory systems of the two countries.

To enable comparison with community Australian studies, the six items in the FWS survey that were in common with other large Australian studies were summed to provide a financial hardship index that could identify those with no hardships, one hardship and two or more financial hardships. Using this index, 67.1% of FWS spouses/partners had not experienced any hardships, 12.7% had experienced one, and 20.2% had experienced two or more. Bennetts Kneebone (2014) reported rates of 83%, 9% and 8% respectively among participants in the 2013 wave of the Household,

Income and Labour Dynamics in Australia (HILDA) Survey; 80%, 12% and 8% for *Growing up in Australia: The Longitudinal Study of Australian Children* (LSAC); 60%, 18% and 22% for *Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants* (BNLA); and 55%, 18% and 27% for *Footprints in Time: The Longitudinal Study of Indigenous Children* (LSIC). Thus, the FWS rates of financial hardship are higher than found in the two community population studies (HILDA and LSAC) but lower than in the more disadvantaged refugee (BNLA) and Indigenous (LSIC) samples. These findings suggest a higher rate of financial disadvantage in the FWS cohort than the general Australian population.

When family members asked about the effect of their ADF members' military service on their financial situation, 46.8% felt it had been positive, 36.3% that there had been no effect, and only 16.8% that it had been negative. Thus, it seemed that military service was seen as a positive contributor to military families' financial wellbeing.

Overall, it seemed that the financial situation of FWS families was sound, given the relatively small percentages reporting each type of financial hardship, and the small percentage feeling there had been negative effects of ADF members' military service on their financial situation. However, they may have been doing slightly less well than the general Australian population, as indicated by comparison to the HILDA and LSAC cohorts, although had not experienced as many hardships as the more disadvantaged LSIC and BNLA cohorts.

Employment

Research and anecdotal accounts suggest that military service may negatively affect spouses'/partners' employment and career prospects (Atkins et al., 2014; Dursun & Sudom, 2009), in part due to the frequent residential relocations that necessitate the seeking of new jobs, or a reduction in hours/cessation of employment that often occurs during deployment so that spouses/partners can care for children and households. Thus, the FWS investigated rates of employment among spouses/partners, and their perceptions of the impact of ADF members' military service on their employment and careers.

A total 68.8% of spouses/partners were working at the time of the FWS, and of those who were working, 60.5% were full-time and 39.5% were part-time. General Australian population data from 2014–15 for women aged between 20 and 74 years shows that 65% were in employment, of whom 56% were full-time and 44% were part-time (Australian Bureau of Statistics, 2016). Thus, the FWS results appear relatively similar to the general Australian female population, although slightly more FWS spouses/partners were full-time and fewer part-time than in the general population of Australian women.

However, FWS spouses/partners tended to be highly qualified educationally, with 47.0% possessing a university degree, 33.9% a post-secondary certificate/diploma, and 19.1% primary or secondary education. Population data show that persons with higher levels of education are more likely to be employed (Australian Bureau of Statistics, 2016). For example, 80% of those with a bachelor degree or above were in employment at May 2016, as were 75% of those with a diploma or certificate, whereas 67% of those with Year 12 and 44% of those with Year 11 or lower were in employment. It is therefore possible that employment may be slightly lower among FWS spouses/partners than among other Australian women with similar levels of educational attainment.

When FWS spouses'/partners' perceptions of the impact of ADF members' military service on spouses'/partners' own employment and careers were examined, 53.6% felt there had been negative effects and only 14.2% felt there had been positive effects. While these findings are concerning, rates of negative perceptions were lower than those reported in the 2012 ADF Families Survey, where approximately 75% of spouses/partners felt their careers had been negatively affected by their ADF member's military career (Atkins et al., 2014). There is also mixed international evidence; for example, close to 40% of Canadian spouses reported that they had made career sacrifices (Dursun & Sudom, 2009), while 75% of US spouses who were working felt there had been negative impacts on their career development. Overall, spouses/partners frequently felt that their ADF members' military service had had a negative effect on spouses'/partners' own employment and careers, with the FWS findings being similar to other Australian and international research (and sometimes slightly better).

Unfortunately, many of the military lifestyle factors that negatively affect spouses'/partners' careers are unavoidable; for example, frequent relocations, or the deployment of a family member. Employment assistance funding is available through the Australian Government Department of Defence to help spouses/partners with employment issues. It could be valuable to undertake further research to determine how effective these supports are perceived to be, and whether there are other tangible actions that could be taken to reduce the effects of military lifestyle factors on civilian spouses'/partners' employment and careers.

Most FWS families seemed to be financially secure, although a higher percentage had experienced one or more financial hardships than in other Australian general community studies. Some negative effects of a military family lifestyle on FWS spouses'/partners' employment and careers were evident in line with much other research, with around one-half feeling their careers had been negatively affected by their ADF members' military service. Hence, it seemed common for spouses/partners to have made career sacrifices to support their ADF members' military careers.

5.2.3 Family wellbeing

Families are a vital resource and influence on current and ex-serving ADF members. Accordingly, there is much interest in how the military family unit is faring, but more Australian information on this issue is needed. A major aim of the FWS was to investigate family wellbeing, and the data that have been collected are expected to be a valuable new resource going forward. The findings next discussed come from the reports of spouses/partners, as they are the most knowledgeable about these aspects of family life.

Couple relationships

An integral part of family wellbeing is how well couples are getting along together (Balfour, Morgan, & Vincent, 2012; Sullivan & Lawrence, 2016). Previous research has shown that relationship quality tends to be high among military couples (e.g. Anderson et al., 2011), although particular characteristics or stages of the service cycle can place stress on relationships (e.g. Keeling et al., 2015; Knobloch & Theiss, 2012).

Most FWS spouses/partners had positive perceptions of their couple relationships, as only around one in five rated this as being unhappy (21.4%). Similarly, most ADF members viewed their couple relationship positively, as 82.5% reported being satisfied to extremely satisfied. These results are consistent with international research from the United States, United Kingdom and Canada showing that around four out of five military personnel or their spouses/partners reported satisfying couple relationships (Anderson et al., 2011; Dursun & Sudom, 2009; Keeling et al., 2015). They are also similar to the Australian Timor-Leste Family Study findings for spouses of ADF members following deployment (McGuire et al., 2012).

There is very little Australian general community data to which these findings can be compared. However, Qu, Soriano and Weston (2006) reported data from the Longitudinal Study of Australian Children (LSAC) on couple relationship happiness and showed that rates of unhappiness were approximately 5.9% among 1,577 new mothers of first-born infants aged 0 to 1 years, a rate considerably smaller than the rate of 21.3% found for FWS spouses/partners. While the LSAC data come from a particular subgroup, it is nevertheless of relevance (especially in light of findings that couples with children tend to report lower relationship quality than childless couples; see the meta-analysis of Twenge, Campbell, & Foster, 2003). Similarly, data from the Household, Income and Labour Dynamics in Australia Survey (Wilkins, 2015) showed mean levels of couple relationship satisfaction of 8.5 among married men and 8.6 among men in de facto relationships in 2012. This compares with mean levels of 8.1 among Current Serving ADF members and 7.9 among Ex-Serving ADF members. These comparisons suggest that while the great majority of FWS spouses/partners and their ADF members were happy in or satisfied with their couple relationship, rates tended to be somewhat lower than in Australian general community samples.

FWS spouses'/partners' assessment of other aspects of their couple relationship tended to be positive (e.g. whether there were problems in the relationship, how well ADF members met spouses'/partners' needs), as most ratings were in the 'high quality' to 'very high quality' range (mean of 4.18 with a maximum possible of 5.0). Again, comparison to the Longitudinal Study of Australian Children on couple relationship quality was slightly lower than the mean of 4.41 found for the 1,577 new mothers of first-born infants (Qu et al., 2006).

Overall, it seemed that most FWS couple relationships were strong, although there were some signs that they were slightly less strong than in general Australian community samples.

Abuse in couple relationships

It has been thought that the pressures of a military lifestyle and its aftermath might lead to higher rates of abuse within military families (Smith-Marek et al., 2016). Abusive relationships are known to take a large toll on victims (Campbell, 2002; Golding, 1999); hence, this issue was addressed in the FWS. Abuse in FWS couple relationships was found to be rare, with only 4.8% of spouses/partners reporting its occurrence at some stage of their relationship. This is lower than found in the Australian Timor-Leste Family Study (McGuire et al., 2012), where 10% reported there had been violence in the relationship post-deployment. The differing rates across the FWS and Timor-Leste Family Study may reflect the effects of recent deployment or combat experiences by the ADF members of families taking part in the Timor-Leste Family Study. Comparison to the general Australian population showed that FWS rates were similar and slightly lower (6.6% of women in the Australian general population, 2012 ABS Personal Safety Survey, Australian Bureau of Statistics, 2014). Overall, it seemed that couples in FWS military families were no more likely to experience abuse in their couple relationships than other Australian couples. This is consistent with international findings that rates of violence and abuse in couple relationships were similar across military and civilian families (Heyman & Neidig, 1999).

Parenting practices

Generally, spouses/partners seemed to be parenting their dependent children effectively, as average mean scores were close to the positive ends of the scales on warmth, use of reasoning, consistency and self-efficacy, and close to the low end on hostility. As the scales do not have norms, it is not possible to identify the percentage of parents who reported less effective parenting. Additionally, comparison to other studies is precluded by the wide age range and small number of FWS dependent children. While data on parenting are available from the Longitudinal Study of Australian Children (LSAC) (e.g. Lucas, Nicholson, & Maguire, 2011; Zubrick, Lucas, Westrupp, & Nicholson, 2014), they are restricted to particular age ranges (e.g. 4 to 5 years, 8 to 9 years). The number of FWS dependent children in specific age ranges,

such as those available from the LSAC, would not be large enough for reliable comparisons. Thus, while we can conclude that most FWS spouses/partners seemed to be parenting effectively based on their mean scores, we cannot determine whether they were parenting more competently, much the same, or less well than other parents in the general Australian population. It should also be noted that as parenting practices were self-reported, they could, to a certain extent, be affected by social desirability (a tendency to present a positive picture of oneself).

On the whole, FWS families appeared to be functioning well.

A total of 78.6% of spouses/partners reported being happy in their couple relationship and most were very positive about the differing features of relationships examined. A slightly higher percentage of ADF members reported being satisfied with their couple relationship (82.5%). Nevertheless, these rates are slightly lower than in some other general community studies, although were high overall.

The prevalence of abuse in couple relationships was very low (4.8%) and similar to general population levels, indicating that FWS couples were not more likely to experience abuse in their couple relationships.

Finally, when asked about their parenting practices, most spouses/partners reported high levels of warmth, consistency and use of reasoning, and low levels of hostility. They also expressed high confidence in their parenting abilities.

5.2.4 Individual wellbeing

We next discuss whether members of FWS military families experience higher rates of mental and physical health problems or more frequently engage in risk-taking than members of the general Australian population.

Mental health

Few spouses/partners (16.8%) and parents (14.4%) were classified as showing high or very high levels of psychological distress, with the prevalence twice as high for adult children (29.0%). Just over one in ten spouses/partners (11.1%), adult children (12.0%) and parents (11.9%) reported high levels of posttraumatic stress disorder (PTSD). Similarly, 13.4% of spouses/partners and 10.6% of parents had thought about taking their own life in the past 12 months, as had 18.0% of adult children. Rates of suicide plans/attempts were low for all types of family members (1.5% of spouses/partners, 2.6% of parents, 4.0% of adult children).

Thus, the great majority of spouses/partners and parents of ADF members were not showing mental health problems, although adult children tended to be faring less well. As noted in the literature review in Chapter 1, published data on the prevalence of mental health problems among differing types of Australian military family members are scarce, although there are some data on specific subpopulations such as the

spouses/partners of deployed personnel, or spouses/partners of military members who are suffering mental health problems. Hence, the FWS findings add to the evidence base on the mental health of Australian military family members.

International data reveal that rates of mental health problems among US military family spouses/partners were very similar to the rates found for FWS spouses/partners (Booth et al., 2007). Thus, the FWS prevalence estimates appear consistent with comparable international research on spouses/partners in military families. The only Australian data we were able to locate relevant to the mental health of FWS adult children come from the Vietnam Veterans Family Study (VVFS) (Forrest et al., 2014). It should be noted that the measures used were not identical – the participants in the VVFS tended to be older (average age of 36 years, whereas 69% of the FWS adult children sample were 18 to 27 years and 31% were 28 to 37 years); the VVFS data are reported separately for the children of veterans who had, or had not, been deployed to Vietnam; and the reference time frames differ (over respondents' lifetime for the VVFS and within the past four weeks or 12 months for the FWS – given the longer reporting time frame, VVFS rates could be expected to be higher than FWS rates). All in all, these comparisons have some limitations that should be borne in mind.

The VVFS found that over the lifetime of adult children of veterans not deployed to Vietnam, 13.6% showed high levels of depression, 12.9% high levels of anxiety, 1.3% had PTSD problems, 31.3% experienced suicidal thoughts and 6.7% had planned or attempted suicide. Among adult children of veterans who had been deployed to Vietnam, lifetime rates were 21.1% for depression, 21.8% for anxiety, 4.3% for PTSD, 40.9% for suicidal ideation and 4.9% for suicide plans or actions. By comparison, rates of mental health problems among FWS adult children were 29.0% for psychological distress in the past four weeks, 12.0% for high levels of PTSD in the past four weeks, and 18.0% for suicidality and 4.0% for suicide plans/actions in the past 12 months.

These comparisons show that despite the shorter time frames used, rates of psychological distress and PTSD were higher among FWS adult children, the occurrence of suicidality was lower, and was similar for suicidal actions. Reasons for the higher rates of mental health difficulties and PTSD symptoms among FWS than VVFS adult children could include the shorter time span between their parents' military service and the collection of information about adult children's mental health; or age and generational differences across the two studies. For example, the greater prevalence of social media, knowledge/awareness of mental health issues, and access to information and support among today's young adults than existed for previous generations may have increased the current cohort's awareness of or willingness to report mental health problems.

General population data on psychological distress for Australian females of differing ages are available from the 2014–15 Australian Health Survey (Australian Bureau of Statistics, 2015). Across all females aged 18 to 75+ years, 13.5% reported high or very high levels of psychological distress. Rates were highest among younger age groups and tended to decline among older age groups (being 20.0% among those aged 18 to 24 years, 11.7% among 25- to 34-year-olds, 13.7% among 35- to 44-year-olds, 15.4% among 45- to 54-year-olds, 12.3% among 55- to 64-year-olds, 10.3% among 65- to 75-year-olds, and 10.6% among those aged 75 or more years). This compares with rates of 16.8% among FWS spouses/partners (90.5% of whom were aged 28 to 57 years), 14.4% among FWS parents (all aged 58 years or older) and 29.0% among FWS adult children (all aged 18 to 37 years).

Thus, comparison with general population data for Australian females indicates that rates of psychological distress were generally similar for FWS spouses/partners and parents, but were 9% higher among adult children than the rate for 18- to 24-year-old Australian females. While FWS data do not shed light on the reasons for the higher rate of psychological distress among FWS adult children than their counterparts in the general community, they do raise concern.

The next issue examined is the wellbeing of dependent children aged 2 to 17 years. This was assessed using the norms provided by the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1995), which identify children showing high levels of behaviour problems or low levels of prosocial skills. In general population samples, it is expected that around 10% of children will be found to have high levels of problems or low levels of prosocial skills. Most children (over 80%) were not reported to have significant levels of behaviour problems. However, FWS rates were higher than general population rates on peer problems (16.9%), emotional symptoms (16.9%) and hyperactivity (15.8%), suggesting that in some specific domains, FWS dependent children may have been faring less well than children in general community samples.

These findings are consistent with other Australian and international research on children in military families (e.g. Chandra et al., 2010; Chartrand et al., 2008; Lester et al., 2010; McGuire et al., 2012). However, most prior research focused on children whose parents were deployed or were experiencing mental health problems. The FWS child sample was not limited to these subpopulations, although as most FWS children had a parent who had been deployed at some stage, our findings could be considered broadly comparable to other research on children whose parents had been deployed. The higher rates of emotional symptoms or peer problems found among FWS dependent children relative to general population rates could suggest that pressures of the military lifestyle have had some emotional and social impacts (although it should be recalled that the great majority did not show high levels of behaviour problems).

These could include the loss of friendships as a result of residential and school relocations or psychological stress experienced while a parent was deployed.

Physical health

While there has been much research on the physical health of current serving and ex-serving military members, there seems to have been little research on the physical health of their family members. This was highlighted in the literature review as a knowledge gap that the FWS aimed to address. Overall, 13.7% of spouses/partners, 8.4% of parents and 8.8% of adult children participating in the FWS reported poor or very poor levels of general physical health. The FWS spouse/partner rate is analogous to the 11% rate reported for spouses/partners in the Australian Timor-Leste Family Study (McGuire et al., 2012). The health status of other types of members of Australian military families (parents and adult children) has not, to our knowledge, been reported before; hence, the FWS data add to the evidence base about these family members. No comparable general Australian population data were located – while other research uses the same question (for example, the 2014–15 Australian Health Survey) (Australian Bureau of Statistics, 2015), the response categories differ, making comparisons unviable.

Risk-taking

Risk-taking is another issue that has been studied among current serving and ex-serving military members but less so among their family members. Risk-taking activities such as problem drinking, illicit drug use and gambling can have large negative impacts on individuals' physical and mental health, their social relationships, and on family wellbeing (Dowling, 2014; Rickwood et al., 2008; World Health Organization, 2004). Accordingly, the FWS examined the prevalence of these behaviours among the spouses/partners, parents and adult children of ADF members.

There were distinct differences in the risk-taking behaviour of adult children by comparison with spouses/partners and parents, with a higher prevalence noted for adult children. This may to a certain extent reflect normative population trends for young people to more often engage in risk-taking (Australian Institute of Health and Welfare (AIHW), 2014), and this may have contributed to the FWS findings. Comparison to general Australian population data is needed to shed light on whether the rates for adult children are higher than expected.

Ten per cent of spouses/partners and 8.1% of parents reported drinking at problem levels, while rates were almost double among adult children (18.6%). We were unable to locate comparable Australian data for military family members, although these rates are higher than the 2% to 4% reported for US spouses/partners of military personnel who were showing alcohol or drug abuse (Booth et al., 2007). However, these differences could be due to the differing outcome measures used (problem drinking in

the FWS and the more stringent alcohol abuse in the US study), and also to cross-cultural differences.

Comparison to the general Australian adult female population is limited by the lack of published data where the Alcohol Use Disorders Identification Test (AUDIT) has been used. Fleming (1996) reported that 8% of an Australian population sample of women were classified as showing hazardous or harmful drinking using an AUDIT cut-off score of 8. This is similar to the rates found for FWS spouses/partners and parents. However, the utility of data collected more than 20 years ago may be questionable as consumption patterns may have changed over this time span. Another possible comparison is to 2015–16 data from New Zealand (Stats NZ, 2017). New Zealand and Australia are similar culturally and therefore New Zealand data could be considered reasonably relevant. The percentages of females scoring 8 or more on the AUDIT index were: 25% of 18- to 24-year-olds, 20% of 25- to 34-year-olds, 14% of 35- to 44-year-olds, 12% of 45- to 54-year-olds, 9% of 55- to 64-year-olds, and 5% of 65- to 74-year-olds. These rates are broadly similar to those found for the FWS cohort and subgroups, suggesting that all three FWS subgroups were not drinking at problem levels more often than general population samples.

Rates of lifetime illicit drug use were 18.5% for spouses/partners, 8.7% for parents, and 39.2% for adult children. Very few spouses/partners (2.0%) and parents (1.5%) had used illicit drugs in the past 12 months, although rates were higher among adult children (14.9%). The Vietnam Veterans Family Study provides comparable data for adult children (although, as noted previously, there are across-study differences that need to be borne in mind). Lifetime illicit drug use among adult children of veterans who had not been deployed to Vietnam was 55.9% and use in the past 12 months was 17.6%. The figures for adult children of Vietnam veterans who had been deployed were 68.4% and 18.4% respectively. Lifetime rates were considerably lower for FWS adult children at 39.2%, and similarly for recent use at 14.9%.

Next, we compare to general Australian population data for females from the 2010 National Drug Strategy Household Survey (AIHW, 2014). A total of 38% of females aged 14 or more years had used illicit drugs in their lifetime and 12% had used illicit drugs in the past 12 months. While the rate of recent use is slightly higher among FWS adult children, it is in fact lower than the general population rate for females aged 20 to 40 years (AIHW, 2014). Overall, it seemed that fewer members of military families had used illicit drugs than in the general Australian population.

More than one in four spouses/partners (28.4%), 31.4% parents, and more than two in five adult children (44.1%) had gambled at least once in the previous 12 months. Australian general population data collected in 2010–11 showed that 46% of females had gambled in the previous 12 months (Gainsbury et al., 2015). Thus, the FWS rates

for spouses/partners and parents are considerably lower than the general female Australian population, while the rates for adult children are similar. The percentage of FWS participants showing signs of gambling problems was 2.7% of spouses/partners, 4.7% of parents and 9.8% of adult children. An Australian population prevalence of 5% for low to high gambling problems was reported by Dowling and colleagues (2016); hence, results for FWS spouses/partners and parents are similar to general population levels. While rates of gambling problems were higher among FWS adult children, they are consistent with other Australian data showing higher rates of gambling problems among Australians aged 18 to 29 years (Armstrong & Carroll, 2017). Hence, rates of gambling problems among FWS participants were similar to general Australian population levels.

Overall, the FWS provides a relatively positive picture of the mental and physical wellbeing of all military family members – spouses/partners, parents and adult children. The majority of these family members were not experiencing mental or physical health problems and did not engage in problem drinking, illicit drug use, or gambling. Nevertheless, rates were higher among adult children, especially on psychological distress, where FWS adult children showed higher rates than Australian females of a similar age. Over four in five of children aged 2 to 17 years did not show high levels of behaviour problems.

Comparison to general Australian population data for females showed that spouses/partners and parents were generally doing well and no worse on all indices of wellbeing. In fact, rates of involvement in illicit drug use and gambling were lower among spouses/partners and parents than in the Australian general female population. However, rates of mental health problems were higher among adult children than in the general Australian female population. Additionally, a greater percentage of 2- to 17-year-old children in families of Current Serving ADF members showed high levels of hyperactivity, emotional symptoms and peer problems than in general community populations. These findings suggest there may be a greater vulnerability to mental health problems among young adults and dependent children in families of Current Serving ADF members.

5.3 Were there differences between families of Current Serving and Ex-Serving ADF members?

The second major question addressed by the FWS was whether family members of Current Serving and Ex-Serving ADF members systematically differed, which could shed light on whether the two subgroups experienced particular challenges. The aspects examined were financial wellbeing, employment, residential mobility, couple relationships, parenting practices, mental and physical health, risk-taking, and their perceptions of the effects of military service.

5.3.1 Differences on employment, finances and mobility

Spouses'/partners' employment did not seem to be related to the military status of ADF members, as there were no significant differences between those with Current Serving and Ex-Serving ADF members on rates of employment, whether spouses/partners were working full- or part-time, their length of employment, and whether they had taken periods of leave of six months or more while in their current job.

There were some indications that families of Ex-Serving ADF members had experienced particular financial pressures in the past two years compared with families of Current Serving ADF members, although they did not significantly differ on the total number of hardships experienced. For example, a significantly higher proportion had not been able to pay the mortgage or rent on time, needed to sell or pawn something, asked for financial help from family or friends, and sought help from community organisations in this time frame (although the prevalence of these behaviours was generally low overall). Other international research shows that the transition to civilian life can be a difficult time financially, with some ex-serving members experiencing reduced incomes, unemployment, or a need to retrain (Black et al., 2007; Loughran, 2014; Sherman et al., 2015; Tanielian & Jaycox, 2008). The FWS findings could reflect the occurrence of such difficulties.

Looking next at residential mobility, civilian spouses/partners of Current Serving ADF members had experienced significantly more moves in total and because of military service than civilian spouses/partners of Ex-Serving ADF members. The high residential mobility resulting from military service can create many stresses for military families, as shown by much other research (e.g. Drummet et al., 2003; Park, 2011; Sheppard et al., 2010). One of the most prominent is a negative effect on civilian spouses'/partners' employment and careers, a finding also evident in the FWS, as discussed in the following sections. On the other hand, dependent children in families of currently and Ex-Serving personnel did not significantly differ on the number of schools attended.

5.3.2 Differences on family relationships

Spouses/partners of Current Serving and Ex-Serving ADF members did not significantly differ on rates of unhappiness in their couple relationships (nor were there significant differences on ADF members' dissatisfaction in the couple relationship). However, spouses/partners of Ex-Serving ADF members tended to rate their relationship quality slightly less positively than spouses/partners of Current Serving ADF members, although relationship quality was high overall. Thus, while couple relationships were generally strong, they seemed a little stronger among spouses/partners with Current Serving ADF members.

While very few spouses/partners reported there had been abuse in their couple relationship, its occurrence was significantly higher among those with Ex-Serving ADF members than those with Current Serving ones (8.4% compared with 3.1%). By comparison, the Australian general population rate of abuse in couple relationships is 6.6% (2012 ABS Personal Safety Survey, Australian Bureau of Statistics, 2014). However, caution is needed when considering the FWS findings, as they reflect the occurrence of abuse at some stage of the relationship and may not have occurred in the period following exit from service. Additionally, we do not know how often abuse occurred; hence, we do not know how typical or atypical it was.

However, an increased risk for abuse in couple relationships is possible in the period after military members leave service, although further Australian research is needed to clarify this (we emphasise again that abusive relationships are still quite atypical during this time). Other research has shown that being in a stable living situation, secure employment, having sufficient finances, feeling that one has control over one's life, and that one has social supports are associated with a lower risk of violence in couple relationships in this period (Elbogen et al., 2012; Elbogen et al., 2014). Unfortunately, research also shows that quite a number of ex-serving members experience difficulties in these areas (Berle & Steele, 2015; Hachey et al., 2016; Tanielian & Jaycox, 2008), which may then put pressure on couple relationships. Overall, our findings are in keeping with other studies in highlighting the importance of supporting military members and their families in the period after leaving service, which for a variety of reasons (as outlined in Chapter 1) may be a particularly stressful period for all concerned.

We look next at whether there were differences in how spouses/partners of Current Serving and Ex-Serving ADF members were parenting their dependent children. A number of parenting practices were assessed: warmth, use of reasoning, consistency, hostility and self-efficacy (confidence in one's parenting skills). Spouses/partners of Current Serving and Ex-Serving ADF members generally did not significantly differ on how they were rearing their children or how well they felt they were carrying out their parenting role. The exception was consistency, which tended to be higher among spouses/partners of Current Serving members, although overall, most spouses/partners reported being very consistent. Thus, generally, it did not seem that spouses/partners of Current Serving and Ex-Serving ADF members systematically differed in how they were parenting their children.

5.3.3 Differences on personal wellbeing

As the period following a military member's exit from service can be stressful for the individual and their family (Berle & Steele, 2015; Hachey et al., 2016), it is possible that family members may be especially vulnerable to mental health problems or risk-taking during this time. Additionally, as discussed in Chapter 2, the Ex-Serving ADF members

whose spouses/partners participated in the FWS tended to show higher levels of generalised anxiety, PTSD symptoms, suicidality and risky drinking than their counterparts whose spouses/partners did not take part. Similar trends were not evident when comparing Current Serving ADF members whose family members did, or did not, participate in the FWS. These findings indicate that Ex-Serving ADF members with participating FWS family members may have been experiencing more mental health problems.

Mental health problems among military members are a known risk for similar problems among spouses/partners, as indicated by considerable prior research (Calhoun et al., 2002; MacDonell et al., 2016; McGuire et al., 2012). Hence, the higher rates evident among Ex-Serving ADF members could be expected to be paralleled by elevated rates of these problems among FWS spouses/partners. Thus, a variety of reasons suggest that spouses/partners of Ex-Serving ADF members might report significantly more mental health problems and risk-taking than the spouses/partners of Current Serving ADF members.

However, this possibility was generally not borne out when indicators of mental and physical health were examined. The spouses/partners, parents and adult children of current and Ex-Serving ADF members were not found to significantly differ on psychological distress, PTSD symptoms, suicidal plans/attempts, or general physical health. The sole exception was the finding that spouses/partners of Ex-Serving ADF members were significantly more likely to report some type of suicidality in the previous 12 months (suicidal thoughts, ideation, plans or attempts) than spouses/partners of Current Serving ADF members (18.3% compared with 11.1%), suggesting they may have recently been experiencing stress.

It was a more mixed picture for risk-taking behaviours such as problem drinking, illicit drug use, and gambling. Spouses/partners of Ex-Serving ADF members were more likely to have used illicit drugs and gambled in the past 12 months, although not over their lifetime (noting illicit drug use in the past 12 months was very low overall). This is despite the fact that risk-taking tends to decrease as age increases (AIHW, 2014), and therefore the levels of risky behaviour of spouses/partners of Ex-Serving ADF members might have been expected to be lower rather than higher, given they were significantly older than the spouses/partners of Current Serving ADF members. While the data do not allow us to determine the reasons, higher rates of recent risk-taking among spouses/partners of Ex-Serving ADF members were evident. There was no statistical evidence that the parents and adult children of current and Ex-Serving ADF members differed in their engagement in any type of risk-taking.

Lastly, there were some indications that 2- to 17-year-old children of Current Serving ADF members were faring less well, with a significantly greater percentage showing

high levels of hyperactivity than children of Ex-Serving ADF members. Additionally, children of Current Serving ADF members more frequently showed high levels of emotional symptoms, although this did not reach the conventional $p \leq 0.05$ criterion ($p = 0.06$). While the FWS data do not allow us to investigate reasons for these differences, it is possible that the findings reflect child age differences, as the children of Current Serving ADF members tended to be significantly younger. Their hyperactivity symptoms might have been more overt, as younger children generally have less cognitive control of their behaviour than older children (Benes, 2001; Hoskyn, Iarocci, & Young, 2017). Another possible explanation could be the effect of ADF members living more than 100 kilometres away from the family home, which was higher among Current Serving than Ex-Serving ADF members (27% compared with 17%). Perhaps the lack of backup and support for the stay-at-home parent affected their capacity to help their child manage his/her hyperactive behaviours. This finding echoes other studies of civilian families showing that children living with a single parent are twice as likely to be identified as having externalising behaviour problems as those living with both biological parents (Meltzer, Gatward, Goodman, & Ford, 2000).

5.3.4 Differences on the effects of military service

Perceptions of the effects of military service provided by the civilian spouses/partners of current serving and ex-serving ADF members are next examined. Those with Current Serving ADF members were more likely to feel there had been negative effects on their employment and careers than those whose ADF members were Ex-Serving. On the other hand, they were also more likely to perceive there had been positive effects on their financial situation. There was no statistical evidence of differences on the effect of military service on their relationships with immediate and wider family members or friends, or their own physical and mental health. In summary, the only areas in which there were substantive differences between civilian spouses/partners of Current Serving and Ex-Serving ADF members were their working life and finances.

Somewhat more parents of Ex-Serving than Current Serving ADF members felt there had been negative effects on them in the areas of their relationships with immediate and wider family members, physical and mental health, employment, careers and financial situation. However, these findings reflect the views of a minority, as the majority of parents felt that their ADF members' military service had not impacted on them at all. Similarly, the sole difference that emerged when the adult children of Current Serving and Ex-Serving ADF members were compared reflected the higher percentage of those with Ex-Serving ADF members who thought there had been no effect. Thus, generally, the parents and adult children of Current Serving and Ex-Serving ADF members believed that their family members' military service had not greatly affected their lives.

In summary, families of Current Serving and Ex-Serving ADF members were similar on many of the aspects examined. However, there were also some signs that spouses/partners of Ex-Serving ADF members were experiencing more difficulties. While couple relationships were generally very strong, spouses/partners of Ex-Serving members tended to be somewhat less positive about the quality of their couple relationship. Additionally, the rate of abuse in couple relationships was higher among spouses/partners with Ex-Serving ADF members (although was very low overall). Spouses/partners of Ex-Serving members had more often reported instances of suicidality in the previous 12 months (suicidal thoughts, ideation, plans or attempts). Finally, they had also more often engaged in problem drinking and illicit drug use in this time period than spouses/partners of Current Serving ADF members, although not in their lifetimes. However, they did not experience significantly more physical health or other types of mental health problems.

Families of Ex-Serving ADF members had also more often experienced particular financial hardships in the past two years, such as not being able to pay the mortgage or rent or time, or needing to sell or pawn something, although did not differ on the total number of hardships experienced. Overall, these findings are consistent with other research showing that the period following exit from service can be a vulnerable time for families.

There were some specific difficulties for spouses/partners of Current Serving ADF members as well. They more frequently perceived that their employment and careers had been negatively affected by their serving members' military career, and their families had experienced significantly more residential moves or relocations, with these two characteristics likely to be related. Both factors can be a source of stress for families. There were also some indications that dependent children of Current Serving ADF members were exhibiting more problem behaviours than children of Ex-Serving ADF members.

Parents and the adult children of ADF members did not seem to be affected by whether their family members were Current Serving or Ex-Serving. Thus, effects of transition from military service seem to mainly be experienced by spouses/partners and the immediate family unit.

5.4 What is the effect of military service on families?

The third major question investigated by the FWS was the perceived effect of military service on family members. A series of questions asked whether there had been positive, negative or no effect on ADF members' and FWS participants' employment, careers and financial situation; relationships with others (immediate and wider family, friends); and personal wellbeing (mental and physical health).

As the focus of the FWS is on the families of ADF members, we look only at how military service has affected family members, rather than the perceived effect of military service on ADF members.

It was not possible to make comparisons to other studies, as there does not seem to be comparable Australian or international data on the impact of military service on family members.

5.4.1 Effect of military service on family members' employment, careers and financial situation

Effects of military service on civilian spouses'/partners' employment, careers and financial situation were discussed earlier in subsections 5.3.1 and 5.3.2, and are therefore not discussed again except to note that around half of spouses/partners felt there had been negative effects on their employment and careers, although on the other hand, a similar percentage felt there had been positive effects on their financial situation. As was pointed out earlier, the negative effects on employment and careers are in line with a large body of prior research.

The perceptions of parents and adult children were markedly different to those of spouses/partners, with 76.2% to 86.8% of parents and 62.2% to 66.7% of adult children feeling that ADF members' military service had not affected their own employment, careers and financial situation. When there were effects, these were a little more likely to be positive. Clearly, ADF members' military service was a very salient issue for spouses'/partners' employment, careers and financial wellbeing, but was much less relevant for the other types of family members who took part in the FWS.

5.4.2 Effect of military service on family members' social relationships

The next area examined is the effect of military service on FWS participants' relationships with immediate and wider family members and friends. Spouses/partners, parents and adult children were similarly more likely to report positive than negative effects, while a reasonably high percentage also felt there had been no effects. For example, 38.9% of spouses/partners reported positive effects and 28.9% negative effects on their relationships with ADF members, while 47.3% felt their ADF members' military service had positive effects on their own relationships with their children and only 18.9% felt there had been negative effects. Overall then, military service seemed to have a more positive than negative impact on FWS participants' relationships with significant others.

5.4.3 Effect of military service on family members' personal wellbeing

Most FWS participants felt that their ADF members' military service had not affected their physical health, with 60.0% of spouses/partners reporting no effects, as did 70.0% of parents and 71.1% of adult children. When respondents thought there had been an effect, they were slightly more likely to perceive this as being positive than negative. Overall, military service did not seem to have much impact on the physical health of all types of military family members.

There were effects on mental health, however, with spouses/partners more frequently affected than parents and adult children. Thus, 43.3% of spouses/partners felt there had been negative effects on their mental health, whereas 14.8% thought there had been positive effects. A further 41.9% felt there had been no effects. Parents and adult children were most likely to feel there had been no effect (58.1% and 53.0% respectively), then negative effects (24.9% and 33.7%), with positive effects the least common (17.1% and 13.3%).

These findings suggest that military service was often perceived to take a toll on the psychological wellbeing of family members. The data cannot specify which aspects of the military lifestyle put pressure on families, although these are likely to include concerns about loved ones' safety during deployment (as more than four-fifths of ADF members had been deployed at least once), the pressures of being a sole parent for spouses/partners when ADF members were deployed or posted far away from home, the effect of residential relocations for service reasons, and concerns about the impacts on children's welfare, and on their own jobs and careers. Nor is it possible to clarify whether negative effects were transient or more entrenched. Further research would be needed to shed light on these issues, which could then provide evidence on whether new policies and services might be needed to assist military families.

ADF members' military service was perceived to have both positive and negative effects on family members, and sometimes no effect at all. Areas in which positive effects predominated were (a) relationships with immediate and wider family members, and (b) for civilian spouses/partners, their financial situation. Areas in which negative effects predominated were mental health, employment and careers for civilian spouses/partners. Areas in which the majority reported no effects were (a) physical health for all types of FWS family members, and (b) mental health, employment, careers and their financial situation for the parents and adult children of ADF members.

Thus, the effects of military service were differentiated both by the areas of life examined, and FWS participants' relationship to their ADF members. Of most concern were the perceived negative effects on all types of FWS participants' mental health, and on spouses'/partners' employment and careers. On the positive side, family relationships were often perceived to be strengthened or not affected by ADF members' military service. Thus, effects of military service on family members were complex and nuanced.

5.5 Help seeking, barriers and unmet need

The fourth major question examined by the FWS was whether military family members had needed services for mental health problems, whether these needs had been met, and if respondents had experienced barriers in obtaining assistance.

Of the spouses/partners who had been concerned about their own mental health (54.4%), 86.6% knew where to obtain help, and 79.5% had sought help. Findings were similar for parents. There were no significant differences between FWS participants whose ADF members were Current Serving or Ex-Serving on their own need for services, knowledge about where to obtain help, and rates of service use. Given that the great majority of FWS participants knew where to obtain help and had done so, there did not seem to be a substantial unmet need for mental health services among FWS family members. However, these results could, to a certain extent, reflect the relatively well-educated nature of the FWS sample, as they may have greater knowledge of the resources available, or capacity to obtain assistance. It is possible that less advantaged samples may exhibit higher levels of unmet need. There may also have been an unmet need for other types of services beyond mental health services, as this was not examined by the FWS.

The FWS findings are more positive than those of the Australian Timor-Leste Family Study, which reported that approximately one-third of spouses/partners felt that barriers would stop those seeking help for mental health problems, with cost being a major deterrent (McGuire et al., 2012). Whether this reflects a change in service provision since the Timor-Leste Family Study was conducted, more effective dissemination of information about services, sampling differences or other reasons is not known, but overall it seemed that Australian services were generally meeting the mental health needs of FWS families, although a small number still reported not knowing where to seek help, or not doing so.

Spouses/partners who had not sought help were asked about the factors that might have prevented them from doing so (they could choose more than one). The most common reasons chosen were feeling that they could still function effectively (89.8%), and preferring to manage on their own (76.5%). However, 33.7% were afraid to ask for help or were concerned about what others would think, while 22.4% felt they could not financially afford to seek help. These findings resonate with those of the Timor-Leste Family Study (McGuire et al., 2012) and international research (Elbogen et al., 2010b; Ross & DeVoe, 2014). Overall, it seemed that the main reasons underlying decisions not to seek assistance from services were inwardly motivated and were much less about external barriers to service access. These findings again suggest that the provision of services for mental health problems was generally adequate for the families taking part in the FWS. However, as the study only measured self-reported access to services, our findings cannot speak to participants' satisfaction with mental health services received or the adequacy of the services provided, and hence cannot shed light on unmet need after the receipt of services.

Overall, there did not appear to be significant unmet need for mental health services among FWS family members, given that the great majority of FWS participants who had concerns about their own mental health knew where to obtain help and had done so. However, the FWS sample tended to be well educated and this may have contributed to the results found. It is possible that less advantaged samples may exhibit higher levels of unmet need.

When asked whether they had experienced barriers to service use, most said they preferred to handle problems independently, with only a minority reporting barriers to service access, such as the cost or stigma arising from service use. It therefore seemed that the reasons for not seeking help for mental health problems were more internally than externally motivated.

5.6 Implications of the multivariate modelling

Multivariate modelling enabled investigation of the factors that were significantly related to FWS family members' health and wellbeing after controlling for the effects of other salient influences. This was the fifth major question examined by the FWS. The predictor variables included ADF members' and FWS participants' personal characteristics (e.g. physical and mental health, highest level of education), service-related factors (e.g. whether ADF members were Current Serving or Ex-Serving, their rank, service length), and family characteristics (e.g. household size, whether there were dependent children in the household). The impact of these factors on FWS participants' *psychosocial functioning* (psychological distress, PTSD, problem drinking), *couple relationships* (satisfaction, quality, abuse in relationships), the *parenting practices* used when rearing children (consistency, hostility, warmth, reasoning, self-efficacy), and *behaviour problems* among children aged 2 to 17 years (total behaviour problems) was investigated.

Before discussing the findings, we first note some constraints to the analyses and their interpretation. While the multivariate models can shed light on associations between predictor variables and outcomes, they cannot determine causality (what leads to what), especially as the predictor variables and outcomes were measured at the same point in time in the FWS. As an example, spouses'/partners' physical and mental health problems were found to be associated with higher levels of unhappiness in couple relationships and the experience of abuse in these relationships, although the direction of effects cannot be determined from our data. It is similarly likely that being unhappy in one's couple relationship or being involved in an abusive relationship could lead to poor mental and physical health, as that poor mental and physical health leads to vulnerability for unhappiness in relationships or abusive relationships. It is also possible that each problem exacerbates the other.

It should also be recalled that the MHWTS responding sample from whom the FWS cohort was derived was to some extent biased towards older, more highly educated, more senior, and female military members than the population from which it was

recruited. If these features are associated with better functioning, which then impacts positively on families, it is possible that fewer risk factors will be identified by our analyses than may have emerged if a more representative sample had been available.

Additionally, due to interrelationships between variables, some potentially influential factors could not be included in the analyses. For example, FWS participant type (spouses/partners, parents, adult children) was highly related to FWS participants' age and both measures could not be included in the same analysis (see Section 4.1. for further discussion of this issue and more examples). Another constraint was the low sample size available for some analyses, which precluded examination of some outcomes of interest (e.g. problem gambling) or necessitated broader coding of a small number of variables in some analyses (e.g. for analyses of parenting practices, 'Non-commissioned Officer' and 'Other rank' were combined because of small cell sizes). Nevertheless, a diverse range of predictor and outcome variables was able to be used, enabling the undertaking of in-depth and informative analyses.

5.6.1 The role of service-related factors

A key aim of the FWS was to determine whether ADF members' service characteristics would be related to FWS participant outcomes after taking into account the effects of other salient variables. The military characteristics examined were: ADF members' Current Serving or Ex-Serving status; rank; type of service; years served in the ADF; whether ever deployed; whether classified as medically fit for service; and whether FWS participants themselves have served in the ADF.

ADF members' current military status was significantly related only to child behaviour problems, with higher levels found among children whose ADF members were Current Serving than Ex-Serving. Possible reasons for this finding have been discussed previously in subsection 5.3.3 and are not repeated here. Otherwise, there were no significant effects of ADF members' Current Serving or Ex-Serving military status.

ADF members' rank was significantly related to several outcomes. Compared to those whose ADF members held a Commissioned Officer rank, FWS participants whose ADF members held an 'other' rank were more likely to experience psychological distress, while those whose ADF members were Non-commissioned Officers were more likely to report lower couple relationship quality. Additionally, spouses/partners whose ADF members were Non-commissioned Officers or held an 'other' rank tended to report less consistency when parenting dependent children than those whose ADF members were Commissioned Officers.

Only one significant difference was found when ADF members' service type was investigated. Relative to those whose ADF members were in the Army, FWS participants whose ADF members were in the Navy tended to report higher levels of

PTSD, but there were no significant differences when comparing to those whose ADF members were in the Air Force. No other significant effects of ADF members' service type were found.

More years of ADF service were related to a reduced risk of PTSD among FWS participants, higher couple relationship quality, and less abuse in couple relationships. However, there were no length-of-service differences on parenting practices or child behaviour problems. Spouses/partners whose ADF members had never been deployed tended to report lower parenting self-efficacy than their counterparts whose ADF members had been deployed, but no other significant effects of deployment were found. Finally, no significant effects were found when ADF members' fitness for military service was investigated.

Some of these findings were unexpected and differ from previous research. For example, deployment has been linked to a range of adverse outcomes, such as spouses'/partners' mental health problems and PTSD, family relationship problems, and behaviour problems among dependent children (e.g. Chandra et al., 2010; Chartrand et al., 2008; Dursun & Sudom, 2009; Gewirtz et al., 2014; Mansfield et al., 2010). However, deployment did not emerge as a significant factor in our analyses, with the exception that it was associated with higher, rather than lower, parenting self-efficacy. Explanation of this finding is difficult, although as noted in Chapter 3, the great majority of ADF members had been deployed (83.2%); hence, it is possible that the small subgroup of families with non-deployed ADF members is atypical in ways that our data cannot reveal. Likewise, military members are thought to experience a range of challenges after they exit from service (e.g. Berle & Steel, 2015; Bowling & Sherman, 2008), suggesting that ex-serving status might have been associated with negative outcomes. However, the only significant finding was in relation to dependent children's behaviour problems, and this revealed a lower rather than higher risk among children whose ADF members were Ex-Serving. Again, this finding was unexpected and is difficult to interpret.

In terms of the other service-related effects found, some prior research suggests that a higher military rank is associated with an easier transition to civilian life (Morin, 2011); hence, the positive effects of the 'Commissioned Officer' rank relative to the 'Other rank' or 'Non-commissioned Officer' categories found here are in line with these findings, although our outcomes differ. There appears to be little Australian research reporting differences by service type, although the 2012 ADF Families Survey (Atkins et al., 2014) found that families of current serving Air Force members tended to report higher wellbeing and less impact of military service on family life than families whose ADF members were currently in another service type. The FWS findings differ, but as there is little research thus far, more research is needed to determine whether there are consistent differences across service types. A greater length of service was

associated with more positive outcomes in the current study, which could reflect a greater capacity for resilience among those who choose to remain in military service rather than leave. This finding is consistent with a recent report of a reduced risk of suicide among ex-serving ADF members who had a longer service history (AIHW, 2017). Nevertheless, further research is needed to augment the scant information available.

The last issue examined in this subsection is whether spouses/partners who had themselves served in the ADF would have significantly different outcomes to their civilian counterparts. Some indications of more difficulties among those who had served emerged after taking into account the effects of other factors. Thus, serving spouses/partners significantly more often reported psychological distress and PTSD, and lower warmth when parenting dependent children. Nevertheless, they were not more likely to report couple relationship difficulties, behaviour problems among dependent children, or less effective parenting in other areas (consistency, hostility, use of reasoning, and self-efficacy).

These findings suggest a greater mental health vulnerability among FWS spouses/partners who have served in the ADF, which is likely due to military lifestyle experiences such as deployment experiences or high rates of residential relocations. While more research is needed, it seems that the pressures of a military lifestyle may affect the mental health of serving spouses/partners, which could suggest a need for additional services and supports for this subgroup.

5.6.2 The role of personal characteristics

One of the most clear-cut findings emerging from the multivariate modelling was the salience of FWS participants' and ADF members' physical and mental health for almost all outcomes, even after including the effects of other variables.

For mental health and risk-taking outcomes (psychological distress, PTSD, problem drinking), only FWS participants' physical health was included, and was found to be significantly associated with the occurrence of these outcomes. As noted previously, caution is needed when interpreting these findings, as we cannot determine whether poor physical health leads to these problems, or the problems lead to poor physical health. For the other outcomes examined, a composite physical and mental health variable was formed, reflecting neither problem (the reference category), poor physical health only, high psychological distress only, and both problems. For all couple relationship outcomes (unhappiness, quality, abuse in the couple relationship as reported by spouses/partners), the presence of spouses'/partners' psychological distress or both problems was associated with an increased risk of all types of couple relationship problems. We caution again that causal pathways cannot be inferred from these data. FWS spouses'/partners' poor physical health was also associated with

higher rates of abuse in couple relationships (although the incidence of abuse was very low overall). Spouses'/partners' psychological distress was associated with poorer parenting self-efficacy and lower consistency, as was the occurrence of both health problems. Additionally, the presence of both problems was a risk for higher levels of hostile parenting. Physical and/or mental health problems were not linked to risk for lower warmth or less use of reasoning when parenting dependent children. Finally, the presence of spouses'/partners' psychological distress or both problems were risks for behaviour problems in dependent children after controlling for the effects of other variables. Again, whether parental psychological problems lead to child behaviour problems or child behaviour problems cause parental psychological distress cannot be determined from our data. Both effects are plausible.

ADF members' physical and mental health problems were also important, but for fewer outcomes. For example, the presence of both problems was associated with lower couple relationship quality. Somewhat surprisingly, ADF members' psychological distress was linked to higher warmth and lower hostility in spouses'/partners' parenting practices after taking the effects of other variables into account, perhaps reflecting spouses'/partners' efforts to shield children from their ADF parents' psychological distress. However, no other associations were found between ADF members' physical and mental health and FWS participant outcomes. ADF members' problem drinking was related to higher levels of problem drinking among FWS participants, and to lower couple relationship quality. There were no other associations between ADF members' problem drinking and the outcomes examined.

Overall, our findings indicate that FWS participants' physical and mental health, and to a lesser extent that of their ADF members, were very salient influences, with effects evident for most outcomes after controlling for the effects of other variables. These findings are consistent with much prior research with military (e.g. Gewirtz et al., 2010; Lester et al., 2010; McGuire et al., 2012; Sayers et al., 2009) and civilian populations (e.g. Barnes & Stein, 2000; Robinson, Rodgers, & Butterworth, 2008; VanDeMark et al., 2005).

The other personal characteristics included in the multivariate models were FWS participants' highest level of educational achievement, whether they were unemployed, and for analyses of couple relationship outcomes, spouses'/partners' age. The other ADF member personal characteristic included was the number of lifetime traumas ADF members had experienced (as reported in their Mental Health and Wellbeing Transition Study surveys).

With the exception that FWS participants with a university degree tended to report slightly poorer quality couple relationships than those with lower levels of education, no effects of FWS participants' educational levels were found. This finding is

inconsistent with some other international research showing links between higher educational achievement and marital satisfaction in civilian populations (e.g. Karney & Bradbury, 1995). Our data cannot shed light on the reasons for this difference and further research is needed to confirm the robustness of the finding and reasons underpinning it.

FWS participants' unemployment was not significantly related to any outcomes. These findings are inconsistent with Trewick and Muller (2014), who found that unemployed spouses from Australian military families reported higher levels of psychological distress and lower quality of life than their employed counterparts. However, the relationship between women's employment and their psychosocial wellbeing can be complex and may be mediated by other factors, such as whether they are married, whether they have dependent children, their employment conditions, job status, and socioeconomic status (see Repetti, Matthews, & Waldron, 1989; Warr & Parry, 1982; Woo, 2009). Hence, it may be unsurprising that the direct associations investigated here were not found.

Spouses'/partners' age was not related to couple relationship outcomes or to dependent child behaviour problems. However, those who were younger tended to report more hostility and less warmth when parenting children than their older counterparts, although did not differ on the other parenting practices examined (consistency, use of reasoning, self-efficacy). Other international research with civilian samples shows that young parental age is a risk for less effective parenting practices (e.g. Woodward, Fergusson, Chesney, & Horwood, 2007) and child behaviour problems (Chudal et al., 2015; Fox, Platz, & Bentley, 1995), although again effects are likely to be mediated by other factors such as psychosocial and socioeconomic factors (López Turley, 2003). Thus, there was some consistency and also inconsistency between the current findings and those of other studies. No significant effects of ADF members' experience of lifetime traumas were found.

Summing up, it seemed that FWS participants' physical and mental health status were the most salient personal characteristics for the outcomes examined. The other personal characteristics investigated did not play a consistent role, although there were occasional significant effects.

5.6.3 The role of family factors

The multivariate modelling also investigated whether family characteristics were significant influences on FWS participant outcomes. The family factors included in the analyses of mental health and risk-taking outcomes were (a) FWS participants' relationship to ADF members (whether they were spouse/partners, parents or adult children); and (b) a larger family size (five or more people in the household compared with 1 to 4 household members). For couple relationship and parenting outcomes,

whether spouses/partners had a dependent child or children with their ADF members was also included, while how they were related to ADF members was dropped (as these analyses used spouse/partner data only). Modelling of child behaviour problems used the same characteristics as the analyses of parenting practices, and two aspects of parenting that have been identified by prior research as particularly salient – consistency and hostility – were also included (Zubrick, Smith, Nicholson, Sanson, & Jackiewicz, 2008).

Some differences were evident when comparing the three main types of FWS participants. Those who were adult children were at higher risk of psychological distress and problem drinking than spouses/partners and parents. There was no statistical evidence of differences on the presence of PTSD symptoms. (These were the only aspects on which the effects of respondent type could be investigated as the other aspects examined – couple relationships, parenting practices and child behaviour problems – used spouse/partner data only.) These differences may to a certain extent reflect normative age effects, as rates of these problems tend to be higher among younger than older adults (Australian Bureau of Statistics, 2015). However, as noted previously in subsection 5.2.4, the proportion of adult children showing psychological distress was higher than in the Australian general population of a similar age and sex, indicating that this subgroup may be more vulnerable to mental health problems. All in all, some military lifestyle effects do seem to be apparent for the adult children subgroup.

Spouses/partners who had a dependent child or children with their ADF members were more likely to report lower couple relationship quality after controlling for the effects of other factors. However, the presence of a dependent child was not a risk for unhappiness in the relationship or the occurrence of abuse in the couple relationship. These were the only aspects on which the presence of dependent children was included in the statistical analyses. Other international research shows that couples who are parents tend to report lower marital satisfaction than those who are not parents (see the meta-analysis of Twenge et al., 2003; also Gabb, Klett-Davies, Fink, & Thomae, 2013); hence, our findings on relationship quality are consistent with this research. Gabb and colleagues (2013) also reported that couples who were parents tended to engage in fewer relationship maintenance activities such as making time for each other or expressing affection than their counterparts who did not have children, which may help to explain these findings.

The size of the family household was related to one aspect of parenting, with a larger household of five or more members being associated with less parenting warmth. Larger family size is known to be related to poorer child academic achievement (e.g. Booth & Kee, 2009; Marks, 2006), but there is less research on whether it is related to parenting practices, although our results are consistent with some previously reported

research (e.g. Lawson & Mace, 2009; Suchman & Luthar, 2000). Wagner, Schubert and Schubert (1985) provide some insight into the specific child-rearing practices that may be affected by family size, reporting that larger families tended to emphasise adherence to rules, made less use of individualised parenting approaches and greater use of corporal punishment, and had fewer resources available to support child rearing. While the FWS findings differ on the specific parenting dimension on which family size effects were evident, they are consistent in showing more negative effects for a larger family size. Nevertheless, this was the only aspect on which there was a family-size effect, with no effects found on FWS participants' physical and mental health outcomes, couple relationship indicators, dependent child behaviour problems, or other types of parenting practices.

The last area in which family effects were found was the association between hostile parenting and higher rates of child behaviour problems. Our data do not allow us to infer the direction of effects: it is possible that child behaviour problems evoke more hostile parenting, or that higher parental hostility leads to acting-out behaviour problems among children or emotional distress. There could also be bidirectional effects, with each behaviour pattern exacerbating the other. Links between negative parenting practices and child behaviour problems are some of the most widely reported findings in the research literature (e.g. Gershoff, 2002; Stormshak, Bierman, McMahon, & Lengua, 2000; Zubrick et al., 2008); hence, our findings are in line with this literature. It should be noted, however, that there were no significant effects of parenting consistency on child behaviour problems in the multivariate modelling.

In summary, the multivariate modelling investigated the variables that were significantly related to outcomes after the effects of other salient influences were taken into account.

The aspect on which the most widespread effects were found was FWS participants' psychological distress, either alone or when combined with poor physical health. Associations were found with all three categories of outcomes: couple relationships, parenting practices and child behaviour problems. Additionally, FWS participants' poor physical health by itself was related to several problematic outcomes. These findings are consistent with a large body of research showing mental and physical health problems can have adverse effects across a broad range of life outcomes. ADF members' mental and/or physical health problems were also found to be significant influences, but not as consistently as those of FWS participants. The other FWS personal characteristics examined (highest level of educational achievement; unemployment) were generally not significantly related to outcomes.

Several service-related characteristics were also important after controlling for the effects of other factors. If ADF members held higher ranks or had a longer service history, then FWS participants' mental health outcomes tended to be more positive and couple relationships tended to be stronger. However, the other aspects of ADF members' service history examined (whether Current Serving or Ex-Serving; service type; deployment; being medically unfit for service) were generally not significantly related to outcomes. Whether FWS participants

themselves had served in the ADF was also a significant influence, with serving spouses/partners being more vulnerable to psychological distress and PTSD and lower on parenting warmth than civilian spouses/partners. These findings could indicate an increased need for services and support among serving spouses/partners.

Only one family factor was related to multiple outcomes after controlling for the effects of other factors. This was being the adult child of one's ADF member, with the adult children subgroup found to be more vulnerable to mental health problems and risky drinking than the spouse/partner and parent subgroups. Our earlier comparison to general population data revealed higher levels of psychological distress in the adult children subgroup by comparison with the civilian population of a similar age and sex, suggesting they might be at an increased risk of mental health problems. The other family factors examined – whether couples had biological children together, a larger household size, and parenting practices – were related to single outcomes only and did not seem to have a consistent effect.

Overall, FWS participants' physical and mental health problems appeared the most salient influences, but ADF members' service rank and length of service were also important, particularly in the areas of FWS participants' psychological wellbeing and couple relationships. Spouses/partners who have served in the ADF and the adult children of ADF members were more likely to experience mental health problems than the other groups to whom they were compared, and may benefit from targeted service and supports.

5.7 Limitations

The FWS had several limitations that should be noted.

As discussed previously, there may be a certain amount of bias in the FWS findings as the ADF members who nominated family members for invitation into the FWS were not completely representative of the wider Programme population from whom they were recruited. Thus, they tended to be older, more highly educated, contain a higher proportion of females, and hold more senior ranks. Additionally, the Army was under-represented while the Air Force was over-represented. If these characteristics are associated with better functioning, which then influences the psychosocial and material wellbeing of military families, the generalisability of the FWS findings beyond the current sample may be affected.

Another limitation is the small size of some of the subgroups recruited. While there were a sufficient number of spouses/partners recruited to the FWS for reliable statistical analyses, fewer individuals were recruited into the parent and particularly the adult children subgroups. When further divided by ADF members' current serving or ex-serving status, or when multivariate modelling was undertaken, the size of various subsamples became more marginal and led to some restrictions. For example, we could not make use of linked ADF member data for parent and adult children subgroups due to the loss of cases that would result. Additionally, for some outcomes

that were rare, the lower statistical power may have limited the detection of significant differences.

A third limitation is the sex imbalance in the FWS sample, with 85% being female. While this is a natural result of the sex imbalance in the MHWTS responding sample from whom they were recruited (most of whom were male), the sex imbalance may mean that the findings provide less insight into outcomes for male non-serving members of military families. For example, it would be interesting to know whether male adult children of ADF members also experience greater psychological distress than young adult males in civilian families similarly to our predominantly female adult children subgroup. Investigation of this issue is not possible in the FWS, but could be undertaken by future research.

Finally, the FWS can shed light on how families of ex-serving ADF members are faring only in the first five years after leaving service, as this was the time span covered by the FWS. It is difficult to know what the longer-term implications might be for families. While it is probable that early difficulties settle down and families adapt to their new circumstances, it is also possible that problems become prolonged for some and difficult to alleviate. Further research would be desirable to examine how families whose ADF members left service a longer time ago are faring, for example 10 years or 15 years after leaving service. It would also be important to compare families who start transition with differing challenges and resources so that those who are likely to have the greatest long-term need for services and supports can be assisted.

The FWS also has a number of strengths. It has provided a rich dataset covering many important areas of life that can shed light on how Australian military families are progressing. The information is up to date and can provide guidance for policy and practice. It provides rare insight into the wellbeing of differing types of family members – spouses/partners, adult children and parents. The study also provides insights into the functioning of military families with current serving and ex-serving ADF members. Finally, the study has enabled evaluation of the impact of ADF members' military status, characteristics, and experiences within the context of other salient family and personal characteristics to increase understanding of their relative contributions.

5.8 Conclusions and implications

The FWS has provided many valuable insights into the physical, psychosocial and material wellbeing of military families. While it yields a generally positive picture, it has also identified particular subgroups who appear to be doing less well and who may benefit from additional support and assistance.

On the positive side, rates of mental health problems among spouses/partners and parents were similar to the general female Australian population. Engagement in risk-

taking such as problem drinking, illicit drug use, and gambling was no more prevalent in all FWS subgroups than in the general female Australian population, with FWS spouses/partners and parents tending to report even lower rates than general population samples. Couple relationships appeared to be strong in most FWS families, and parents' self-reports suggested they were rearing children effectively (although the self-reports could to a certain extent be affected by social desirability – the tendency for respondents to present a favourable view of themselves).

However, some findings reflecting particular difficulties were also evident. For example, a higher percentage of dependent children aged 2 to 17 years in families of Current Serving ADF members showed higher levels of emotional, hyperactive or peer problems than would be expected normatively (although the majority of children did not show these problems). Dependent children may be particularly sensitive to the negative effects of a military family lifestyle; for example, the effects of frequent residential relocations and school changes while growing up, or the disruptions, stresses and increased responsibilities experienced when a parent is deployed or living far away from home. However, similarly aged children in families of Ex-Serving ADF members did not show higher levels of problems than the general child population (with the exception of peer problems). Thus, the FWS provides some evidence of greater-than-expected difficulties among dependent children in families in which ADF members are still serving.

Likewise, a higher proportion of adult children aged 18 to 37 years reported problematic levels of psychological distress than did the Australian population of a similar age and sex. Further research on the adult children of ADF members is needed to shed light on the factors that place them at risk of mental health problems (the small size of the FWS adult children subgroup precludes such analyses). While the FWS has highlighted this subgroup's greater risk, it is not able to provide further insight into the factors and experiences that increase vulnerability.

The FWS findings also draw attention to the mental health difficulties of spouses/partners who have served in the ADF, with mental health problems in this subgroup significantly more prevalent than in civilian FWS spouses/partners. While we cannot determine why they might be at greater risk, it is likely due to aspects of military service or the military family lifestyle such as deployment experiences, service relocations or social network disruptions. Again, additional research would be valuable to enhance understanding of the factors that increase risk, and to provide guidance for the targeting of services and support.

In line with much other research on military families, the FWS found that military service tended to negatively impact on spouses'/partners' employment, with this particularly an issue for spouses/partners of Current Serving ADF members. It was

common for spouses/partners to feel they had made career sacrifices to support their ADF members' military careers. There were also some indications that slightly fewer spouses/partners were in employment than would be expected for females of a similar educational background. Negative effects on spouses'/partners' careers are a well-established drawback of the military family lifestyle, and in recognition of this, the Australian Government Department of Defence provides a range of programs and supports for military families. It could be of value to seek feedback on whether there are other actions that could be taken to assist families.

A major aim of the FWS was to compare the families of Current Serving and Ex-Serving ADF members to determine whether there are particular issues for families in the period following exit from service. Overall, the two subgroups of families were similar and only a limited number of significant differences were found, suggesting that most FWS families have coped well with this potentially difficult period. However, there were some indications of difficulties among spouses/partners of Ex-Serving ADF members that seemed to be linked to their current life circumstances. For example, they reported significantly greater involvement in illicit drug use and gambling in the past 12 months, although had not reported greater lifetime engagement in these activities. Additionally, spouses/partners of Ex-Serving ADF members tended to be somewhat less positive about their couple relationship and to more often report abuse in the couple relationship than spouses/partners of Current Serving ADF members. The period following exit from service can be a vulnerable time for serving members and our findings suggest it may be for spouses/partners as well. Prioritising service provision and supports at this time could thus have valuable pay-offs for ex-serving members and their spouses/partners and families.

In conclusion, the FWS has revealed that most military families who took part were progressing well. It has also provided insight into subgroups experiencing difficulties and identified some potential areas for policy development and support.

Appendix A Data collection methodology

ARTD Consultants was contracted by the Australian Institute of Family Studies (AIFS) to undertake data collection for the Family Wellbeing Study (FWS) survey. They were provided with survey items developed by AIFS to be implemented into a sophisticated online survey containing 273 required survey items and 1,115 outcome variables. The survey included detailed skip logic and coding to personalise and tailor the survey to individual respondents. For example, respondents were shown questions relevant to the name and sex of their ADF member, as well as the name, sex and age of their child. This strategy was used to increase accuracy in interpreting the questions and created a highly personalised experience for each respondent.

The survey was pilot tested during July 2015 with extensive technical testing and cognitive interviewing to improve clarity, structure and the appearance of the survey. For the pilot test, a stratified random sample of 300 nominees were selected and sent invitations to participate in the FWS. During completion of the online survey, they were asked to provide consent for a follow-up interview about their experience of participating in the study. Those who consented were later contacted and participated in cognitive interviews, which provided direct feedback from respondents and allowed further tailoring of the survey to improve its structure and appearance.

The main survey was conducted between 4 September 2015 and 29 February 2016. As outlined above, nominations for the FWS survey came from current ADF members, transitioned members and reservists completing the Mental Health and Wellbeing Transition Study survey undertaken by the Centre for Traumatic Stress Studies.

An online portal allowed FWS respondents to be segmented into six batches so invitations were sent in a timely manner soon after the original nominations were made. Nominees were sent paper invitations and information packs with instructions on how to access the FWS survey online. Where mailing addresses were not available, an email containing the same information was sent.

Invitations were followed with up to five reminders by email, text message and phone call. A total of 12,282 attempts to contact nominees were made. Nominees received three email reminders asking them to complete the survey. These reminders were sent two, four, and six weeks after the initial invitations. For nominees in Batch 1 only, the second reminder was sent via post. For all other batches, the reminders were sent via email. Nominees also received a final reminder before the survey closed. This final reminder was a phone call followed up with an email or SMS message.

Appendix B Details of nomination and response rates for MHWTS and FWS respondents, by MHWTS military status

Tables B.1 and B.2 show the flow of participants through the Mental Health and Wellbeing Transition Study (MHWTS) and Family Wellbeing Study (FWS).

Table B.1 Current Serving ADF members

MHWTS	52,510	ADF members Current Serving	
	20,041	ADF members invited to participate	
	32,469	ADF members not invited to participate	
	8,490	ADF members participated	
	11,551	ADF members did not participate	
	1,912	ADF members nominated 2,467 family members	
	6,578	ADF members did not nominate anyone	
	1,577	ADF members agreed to inform 2,085 family members about being nominated	
	334	ADF members did not agree to inform 378 family members about being nominated	
	1,577	ADF members provided details of 2,085 eligible family members	
	1	ADF member provided details of no eligible family members	
FWS	2,085	family members were contacted for 1,577 ADF members	
	219	family members were not contacted for 195 ADF members	
		219	No contact details
	1,021	family members were recruited for 951 ADF members	
	1,064	family members were not recruited of 626 ADF members	
		158	No valid contact details
		1,222	Non-response
	929	family members in analysis sample for 870 ADF members	
	92	family members were excluded from analysis sample for 81 ADF members	
		3	Underage (< 18 years of age)
		5	ADF member participated instead of FWS member
		1	No relationship data
		83	Incomplete data
	817	family members in analysis sample with linked data for 760 ADF members	
	112	family members in analysis sample with no linked data for 110 ADF members	

Table B.2 Ex-Serving ADF members

MHWTS	24,943	ADF members Ex-Serving	
	23,985	ADF members invited to participate	
	958	ADF members not invited to participate	
	4,337	ADF members participated	
	19,648	ADF members did not participate	
	985	ADF members nominated 1,285 family members	
	3,352	ADF members did not nominate anyone	
	871	ADF members agreed to inform 1,098 family members about being nominated	
	114	ADF members did not agree to inform 187 family members about being nominated	
	827	ADF members provided details of 1,098 eligible family members	
FWS	1,098	family members were contacted for 827 ADF members	
	0	family members were not contacted for 0 ADF members	
		0	No contact details
	512	family members were recruited for 477 ADF members	
	586	family members were not recruited for 350 ADF members	
		87	No valid contact details
		499	Non-response
	458	family members in analysis sample for 428 ADF members	
	54	family members were excluded from analysis sample for 49 ADF members	
		0	Underage (< 18 years of age)
		1	ADF member participated instead of FWS member
		1	No relationship data
		52	Incomplete data
	400	family members in analysis sample with linked data for 426 ADF members	
	58	family members in analysis sample with no linked data for 30 ADF members	

Appendix C Effects of military service, perceptions of all FWS respondents

Table C.1 Effect of military service on ADF members, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their immediate family								0.02
Negative	25.5	199	23.1	(20.4 – 26.1)	131	30.2	(26.0 – 34.7)	
No influence	35.9	313	36.4	(33.2 – 39.6)	152	35.0	(30.7 – 39.7)	
Positive	38.6	349	40.5	(37.3 – 43.9)	151	34.8	(30.4 – 39.4)	
Missing		68			24			
Relationships with their wider family								0.09
Negative	19.2	145	17.5	(15.1 – 20.3)	94	22.5	(18.8 – 26.8)	
No influence	43.9	367	44.3	(41.0 – 47.7)	180	43.2	(38.5 – 48.0)	
Positive	36.9	316	38.2	(34.9 – 41.5)	143	34.3	(29.9 – 39.0)	
Missing		101			41			
Relationships with their friends								0.003
Negative	20.5	152	17.8	(15.4 – 20.5)	109	26.0	(22.0 – 30.4)	
No influence	28.3	245	28.7	(25.8 – 31.9)	115	27.4	(23.3 – 31.9)	
Positive	51.2	456	53.5	(50.1 – 56.8)	196	46.7	(41.9 – 51.5)	
Missing		76			38			
Employment								< 0.0001
Negative	15.7	79	9.6	(7.7 – 11.8)	118	27.6	(23.6 – 32.1)	
No influence	14.5	126	15.3	(13.0 – 17.9)	56	13.1	(10.2 – 16.7)	
Positive	69.8	621	75.2	(72.1 – 78.0)	253	59.3	(54.5 – 63.8)	
Missing		103			31			
Physical health								< 0.0001
Negative	32.5	220	24.8	(22.0 – 27.7)	211	48.0	(43.3 – 52.6)	
No influence	12.8	116	13.1	(11.0 – 15.4)	54	12.3	(9.5 – 15.7)	
Positive	54.7	552	62.2	(58.9 – 65.3)	175	39.8	(35.3 – 44.4)	
Missing		41			18			
Mental health								< 0.0001
Negative	46.2	336	39.3	(36.0 – 42.6)	255	60.3	(55.5 – 64.9)	
No influence	18.1	173	20.2	(17.6 – 23.0)	59	13.9	(11.0 – 17.6)	
Positive	35.6	347	40.5	(37.3 – 43.9)	109	25.8	(21.8 – 30.2)	
Missing		73			35			

Measure	Military status of ADF member							
	All (n = 1,387)	Current (n = 929)			Ex-serving (n = 458)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Financial situation								< 0.0001
Negative	11.7	64	7.2	(5.6 – 9.1)	91	21.1	(17.5 – 25.2)	
No influence	13.3	99	11.1	(9.2 – 13.3)	77	17.8	(14.5 – 21.7)	
Positive	75.0	730	81.7	(79.1 – 84.1)	264	61.1	(56.4 – 65.6)	
Missing		36			26			
Career								< 0.0001
Negative	17.2	115	13.1	(11.1 – 15.6)	109	25.5	(21.6 – 29.9)	
No influence	10.5	71	8.1	(6.5 – 10.1)	66	15.5	(12.3 – 19.2)	
Positive	72.3	689	78.7	(75.9 – 81.3)	252	59.0	(54.3 – 63.6)	
Missing		54			31			

Note: 95% CI = 95% confidence interval.

Table C.2 **Effect of FWS respondents' own current or former military service on themselves, stratified by military status of ADF member**

Measure	Military status of ADF member							p-value
	All (n = 236)	Current (n = 159)			Ex-serving (n = 77)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their immediate family								0.25
Negative	13.6	24	16.3	(11.1 – 23.3)	6	8.2	(3.7 – 17.4)	
No influence	37.7	53	36.1	(28.6 – 44.2)	30	41.1	(30.2 – 52.9)	
Positive	48.6	70	47.6	(39.6 – 55.8)	37	50.7	(39.1 – 62.2)	
Missing		12			< 5			
Relationships with their wider family								0.22
Negative	10.6	18	12.7	(8.1 – 19.3)	5	6.7	(2.7 – 15.3)	
No influence	47.9	70	49.3	(41.1 – 57.6)	34	45.3	(34.2 – 56.9)	
Positive	41.5	54	38.0	(30.3 – 46.4)	36	48.0	(36.7 – 59.5)	
Missing		17			< 5			
Relationships with their friends								0.76
Negative	16.6	25	16.8	(11.5 – 23.7)	12	16.2	(9.3 – 26.7)	
No influence	35.4	55	36.9	(29.5 – 45.0)	24	32.4	(22.6 – 44.1)	
Positive	48.0	69	46.3	(38.4 – 54.4)	38	51.4	(39.8 – 62.7)	
Missing		10			< 5			
Employment								0.60
Negative	12.2	19	12.8	(8.2 – 19.2)	8	11.1	(5.6 – 21.0)	
No influence	18.6	30	20.1	(14.4 – 27.4)	11	15.3	(8.5 – 25.8)	
Positive	69.2	100	67.1	(59.1 – 74.3)	53	73.6	(62.0 – 82.7)	
Missing		10			< 5			
Physical health								0.23
Negative	22.0	38	25.2	(18.8 – 32.8)	12	15.8	(9.1 – 26.1)	
No influence	17.6	27	17.9	(12.5 – 24.9)	13	17.1	(10.1 – 27.5)	
Positive	60.4	86	57.0	(48.9 – 64.7)	51	67.1	(55.6 – 76.9)	
Missing		8			< 5			
Mental health								0.33
Negative	33.8	55	36.7	(29.3 – 44.8)	20	27.8	(18.5 – 39.5)	
No influence	24.3	33	22.0	(16.0 – 29.4)	21	29.2	(19.7 – 40.9)	
Positive	41.9	62	41.3	(33.6 – 49.5)	31	43.1	(31.9 – 54.9)	
Missing		9			5			
Financial situation								0.28
Negative	5.8	6	4.0	(1.8 – 8.7)	7	9.2	(4.4 – 18.4)	
No influence	24.0	37	24.8	(18.5 – 32.5)	17	22.4	(14.2 – 33.4)	
Positive	70.2	106	71.1	(63.3 – 77.9)	52	68.4	(56.9 – 78.0)	
Missing		10			< 5			
Career								0.49
Negative	13.8	23	15.8	(10.6 – 22.7)	7	9.9	(4.7 – 19.6)	
No influence	23.5	34	23.3	(17.1 – 30.9)	17	23.9	(15.3 – 35.5)	
Positive	62.7	89	61.0	(52.7 – 68.6)	47	66.2	(54.2 – 76.4)	
Missing		13			6			

Note: 95% CI = 95% confidence interval.

Table C.3 Effect of ADF members' military service on civilian FWS respondents, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 1,151)	Current (n = 770)			Ex-serving (n = 381)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their immediate family								0.04
Negative	20.6	143	19.7	(17.0 – 22.8)	81	22.4	(18.4 – 27.1)	
No influence	46.6	327	45.0	(41.4 – 48.7)	180	49.9	(44.7 – 55.0)	
Positive	32.8	256	35.3	(31.9 – 38.8)	100	27.7	(23.3 – 32.6)	
Missing		44			20			
Relationships with their wider family								0.02
Negative	17.0	116	16.1	(13.6 – 19.0)	67	18.7	(15.0 – 23.1)	
No influence	55.1	383	53.3	(49.6 – 56.9)	210	58.7	(53.5 – 63.7)	
Positive	27.9	220	30.6	(27.3 – 34.1)	81	22.6	(18.6 – 27.3)	
Missing		51			23			
Relationships with their friends								0.01
Negative	23.1	170	23.5	(20.6 – 26.8)	80	22.2	(18.2 – 26.8)	
No influence	46.8	317	43.8	(40.3 – 47.5)	190	52.6	(47.4 – 57.8)	
Positive	30.2	236	32.6	(29.3 – 36.2)	91	25.2	(21.0 – 30.0)	
Missing		47			20			
Employment								0.0001
Negative	41.0	318	45.3	(41.6 – 49.0)	117	32.7	(28.0 – 37.7)	
No influence	43.7	276	39.3	(35.8 – 43.0)	187	52.2	(47.0 – 57.4)	
Positive	15.3	108	15.4	(12.9 – 18.3)	54	15.1	(11.7 – 19.2)	
Missing		68			23			
Physical health								0.13
Negative	17.5	118	16.4	(13.9 – 19.3)	71	19.6	(15.8 – 24.0)	
No influence	62.6	446	62.1	(58.5 – 65.6)	231	63.6	(58.5 – 68.4)	
Positive	19.9	154	21.4	(18.6 – 24.6)	61	16.8	(13.3 – 21.0)	
Missing		52			18			
Mental health								0.03
Negative	38.8	263	36.3	(32.8 – 39.9)	158	43.9	(38.8 – 49.1)	
No influence	46.0	342	47.2	(43.6 – 50.8)	157	43.6	(38.6 – 48.8)	
Positive	15.2	120	16.6	(14.0 – 19.4)	45	12.5	(9.5 – 16.4)	
Missing		45			21			
Financial situation								< 0.0001
Negative	16.8	108	15.1	(12.7 – 17.9)	73	20.2	(16.4 – 24.7)	
No influence	36.3	233	32.6	(29.2 – 36.1)	158	43.8	(38.7 – 49.0)	
Positive	46.8	374	52.3	(48.6 – 56.0)	130	36.0	(31.2 – 41.1)	
Missing		55			20			
Career								< 0.0001
Negative	41.2	317	45.8	(42.1 – 49.5)	112	32.0	(27.3 – 37.1)	
No influence	45.3	285	41.2	(37.6 – 44.9)	187	53.4	(48.2 – 58.6)	
Positive	13.5	90	13.0	(10.7 – 15.7)	51	14.6	(11.2 – 18.7)	
Missing		78			31			

Note: 95% CI = 95% confidence interval.

Appendix D Effects of military service, perceptions of spouses/partners

Table D.1 Effect of military service on ADF members, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their partner								0.34
Negative	27.2	154	27.5	(23.9 – 31.4)	68	26.7	(21.6 – 32.5)	
No influence	29.9	159	28.4	(24.8 – 32.3)	85	33.3	(27.8 – 39.4)	
Positive	42.8	247	44.1	(40.0 – 48.3)	102	40.0	(34.1 – 46.2)	
Missing		36			17			
Relationships with their children*								0.95
Negative	36.8	168	36.5	(32.2 – 41.0)	76	37.4	(31.0 – 44.4)	
No influence	24.9	114	24.8	(21.0 – 29.0)	51	25.1	(19.6 – 31.6)	
Positive	38.3	178	38.7	(34.3 – 43.2)	76	37.4	(31.0 – 44.4)	
Missing		25			11			
Relationships with other immediate family								0.39
Negative	26.9	141	25.5	(22.0 – 29.3)	78	30.0	(24.7 – 35.9)	
No influence	38.1	216	39.0	(35.0 – 43.1)	94	36.2	(30.5 – 42.2)	
Positive	35.0	197	35.6	(31.7 – 39.7)	88	33.8	(28.3 – 39.9)	
Missing		42			12			
Relationships with their wider family								0.79
Negative	20.8	108	20.1	(17.0 – 23.8)	56	22.1	(17.4 – 27.7)	
No influence	46.1	248	46.3	(42.1 – 50.5)	116	45.8	(39.8 – 52.1)	
Positive	33.1	180	33.6	(29.7 – 37.7)	81	32.0	(26.5 – 38.1)	
Missing		60			19			
Relationships with their friends								0.18
Negative	21.1	108	19.3	(16.2 – 22.8)	64	25.0	(20.0 – 30.7)	
No influence	29.8	171	30.6	(26.9 – 34.5)	72	28.1	(22.9 – 34.0)	
Positive	49.1	280	50.1	(45.9 – 54.2)	120	46.9	(40.8 – 53.0)	
Missing		37			16			
Employment								< 0.0001
Negative	15.7	56	10.4	(8.1 – 13.3)	68	26.9	(21.7 – 32.7)	
No influence	14.8	89	16.6	(13.7 – 20.0)	28	11.1	(7.7 – 15.6)	
Positive	69.5	391	72.9	(69.0 – 76.6)	157	62.1	(55.9 – 67.9)	
Missing		60			19			

Measure	Military status of ADF member							
	All (n = 868)	Current (n = 596)			Ex-serving (n = 272)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Physical health								< 0.0001
Negative	33.8	158	27.3	(23.8 – 31.1)	126	48.3	(42.2 – 54.4)	
No influence	12.1	75	13.0	(10.4 – 16.0)	27	10.3	(7.2 – 14.7)	
Positive	54.1	346	59.8	(55.7 – 63.7)	108	41.4	(35.5 – 47.5)	
Missing		17			11			
Mental health								< 0.0001
Negative	48.3	238	42.0	(38.0 – 46.2)	161	61.9	(55.8 – 67.7)	
No influence	18.6	125	22.1	(18.8 – 25.7)	29	11.2	(7.8 – 15.6)	
Positive	33.1	203	35.9	(32.0 – 39.9)	70	26.9	(21.9 – 32.7)	
Missing		30			12			
Financial situation								< 0.0001
Negative	11.8	46	8.0	(6.0 – 10.5)	53	20.5	(16.0 – 25.9)	
No influence	13.4	64	11.1	(8.8 – 13.9)	48	18.5	(14.2 – 23.8)	
Positive	74.8	468	81.0	(77.6 – 84.0)	158	61.0	(54.9 – 66.8)	
Missing		18			13			
Career								< 0.0001
Negative	18.1	81	14.4	(11.7 – 17.6)	66	26.3	(21.2 – 32.1)	
No influence	10.2	48	8.5	(6.5 – 11.2)	35	13.9	(10.2 – 18.8)	
Positive	71.7	433	77.0	(73.4 – 80.3)	150	59.8	(53.5 – 65.7)	
Missing		34			21			

* Only asked of FWS participants who have children with ADF member (All n = 868; Current n = 485; Ex-serving n = 214).
Note: 95% CI = 95% confidence interval.

Table D.2 Effect of ADF members' service on civilian spouses/partners, stratified by military status of ADF member

Measure	Military status of ADF member							p-value
	All (n = 716)	Current (n = 489)			Ex-serving (n = 227)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their partner								0.08
Negative	28.9	134	29.5	(25.5 – 33.9)	58	27.6	(22.0 – 34.1)	
No influence	32.2	134	29.5	(25.5 – 33.9)	80	38.1	(31.7 – 44.9)	
Positive	38.9	186	41.0	(36.5 – 45.6)	72	34.3	(28.1 – 41.0)	
Missing		35			17			
Relationships with their children*								0.58
Negative	18.9	67	18.1	(14.5 – 22.3)	36	20.8	(15.4 – 27.6)	
No influence	38.8	142	38.3	(33.4 – 43.4)	69	39.9	(32.8 – 47.4)	
Positive	42.3	162	43.7	(38.7 – 48.8)	68	39.3	(32.2 – 46.8)	
Missing		28			9			
Relationships with other immediate family								0.22
Negative	22.3	106	22.7	(19.2 – 26.8)	46	21.5	(16.5 – 27.6)	
No influence	45.3	201	43.1	(38.7 – 47.7)	107	50.0	(43.3 – 56.7)	
Positive	32.4	159	34.1	(29.9 – 38.6)	61	28.5	(22.8 – 35.0)	
Missing		23			13			
Relationships with their wider family								0.24
Negative	18.5	86	18.5	(15.2 – 22.3)	39	18.4	(13.7 – 24.2)	
No influence	53.8	241	51.9	(47.4 – 56.5)	123	58.0	(51.2 – 64.5)	
Positive	27.7	137	29.5	(25.5 – 33.9)	50	23.6	(18.3 – 29.8)	
Missing		25			15			
Relationships with their friends								0.15
Negative	27.9	135	28.8	(24.9 – 33.1)	56	25.9	(20.5 – 32.2)	
No influence	42.8	189	40.3	(35.9 – 44.8)	104	48.1	(41.5 – 54.9)	
Positive	29.3	145	30.9	(26.9 – 35.3)	56	25.9	(20.5 – 32.2)	
Missing		20			11			
Employment								0.0006
Negative	53.1	267	57.9	(53.3 – 62.4)	92	42.8	(36.3 – 49.5)	
No influence	31.4	125	27.1	(23.2 – 31.4)	87	40.5	(34.1 – 47.2)	
Positive	15.5	69	15.0	(12.0 – 18.5)	36	16.7	(12.3 – 22.4)	
Missing		28			12			
Physical health								0.75
Negative	19.4	93	19.7	(16.4 – 23.6)	40	18.5	(13.9 – 24.3)	
No influence	60.0	278	59.0	(54.5 – 63.4)	134	62.0	(55.3 – 68.3)	
Positive	20.7	100	21.2	(17.8 – 25.2)	42	19.4	(14.7 – 25.3)	
Missing		18			11			

Measure	Military status of ADF member							
	All (n = 716)	Current (n = 489)			Ex-serving (n = 227)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Mental health								0.41
Negative	43.3	196	41.8	(37.4 – 46.3)	99	46.5	(39.8 – 53.3)	
No influence	41.9	199	42.4	(38.0 – 47.0)	87	40.8	(34.4 – 47.6)	
Positive	14.8	74	15.8	(12.7 – 19.4)	27	12.7	(8.8 – 17.9)	
Missing		20			14			
Financial situation								0.0001
Negative	20.0	86	18.3	(15.0 – 22.0)	51	23.7	(18.5 – 29.9)	
No influence	22.9	91	19.3	(16.0 – 23.2)	66	30.7	(24.9 – 37.2)	
Positive	57.1	294	62.4	(57.9 – 66.7)	98	45.6	(39.0 – 52.3)	
Missing		18			12			
Career								0.0004
Negative	53.6	266	58.6	(54.0 – 63.1)	89	42.8	(36.2 – 49.7)	
No influence	32.2	126	27.8	(23.8 – 32.1)	87	41.8	(35.3 – 48.7)	
Positive	14.2	62	13.7	(10.8 – 17.1)	32	15.4	(11.1 – 21.0)	
Missing		35			19			

* Only asked of FWS participants who have children with ADF member (All n = 716; Current n = 399; Ex-serving n = 182).
Note: 95% CI = 95% confidence interval.

Table D.3 Effect of spouses'/partners' own current or former military service on their own wellbeing, stratified by military status of ADF member

Measure	Military status of ADF member							
	All (n = 152)	Current (n = 107)			Ex-serving (n = 45)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their partner								0.28
Negative	16.9	17	16.7	(10.5 – 25.4)	7	17.5	(8.3 – 33.2)	
No influence	23.9	28	27.5	(19.6 – 37.1)	6	15.0	(6.7 – 30.4)	
Positive	59.2	57	55.9	(46.0 – 65.3)	27	67.5	(51.0 – 80.6)	
Missing		5			5			
Relationships with their children*								0.41
Negative	15.5	15	18.1	(11.1 – 28.1)	< 5	7.4	(1.7 – 27.2)	
No influence	36.4	29	34.9	(25.3 – 46.0)	11	40.7	(23.2 – 61.0)	
Positive	48.2	39	47.0	(36.3 – 57.9)	14	51.9	(32.5 – 70.7)	
Missing		< 5			5			
Relationships with other immediate family								0.34
Negative	13.4	16	16.0	(10.0 – 24.7)	<5	7.1	(2.2 – 20.7)	
No influence	40.1	38	38.0	(28.9 – 48.0)	19	45.2	(30.5 – 60.9)	
Positive	46.5	46	46.0	(36.3 – 56.0)	20	47.6	(32.6 – 63.1)	
Missing		7			< 5			
Relationships with their wider family								0.45
Negative	10.6	12	12.2	(7.0 – 20.5)	< 5	7.0	(2.2 – 20.3)	
No influence	51.8	52	53.1	(43.0 – 62.9)	21	48.8	(33.9 – 64.0)	
Positive	37.6	34	34.7	(25.8 – 44.8)	19	44.2	(29.7 – 59.7)	
Missing		9			< 5			
Relationships with their friends								0.45
Negative	18.5	18	17.5	(11.2 – 26.2)	9	20.9	(11.0 – 36.3)	
No influence	35.6	40	38.8	(29.8 – 48.7)	12	27.9	(16.2 – 43.7)	
Positive	45.9	45	43.7	(34.3 – 53.5)	22	51.2	(36.0 – 66.1)	
Missing		< 5			< 5			
Employment								0.96
Negative	12.5	13	12.6	(7.4 – 20.7)	5	12.2	(5.0 – 26.9)	
No influence	20.8	22	21.4	(14.4 – 30.5)	8	19.5	(9.8 – 35.2)	
Positive	66.7	68	66.0	(56.2 – 74.6)	28	68.3	(52.0 – 81.1)	
Missing		< 5			< 5			
Physical health								0.31
Negative	21.6	26	25.0	(17.5 – 34.4)	6	13.6	(6.1 – 27.9)	
No influence	18.9	19	18.3	(11.9 – 27.0)	9	20.5	(10.7 – 35.5)	
Positive	59.5	59	56.7	(46.9 – 66.0)	29	65.9	(50.3 – 78.7)	
Missing		< 5			< 5			

Measure	Military status of ADF member							
	All (n = 152)	Current (n = 107)			Ex-serving (n = 45)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Mental health								0.47
Negative	33.8	38	36.5	(27.7 – 46.4)	11	26.8	(15.1 – 43.0)	
No influence	26.2	25	24.0	(16.7 – 33.3)	13	31.7	(18.9 – 48.0)	
Positive	40.0	41	39.4	(30.4 – 49.3)	17	41.5	(27.0 – 57.5)	
Missing		< 5			< 5			
Financial situation								0.15
Negative	4.7	< 5	2.9	(0.9 – 8.7)	< 5	9.1	(3.3 – 22.6)	
No influence	25.0	24	23.1	(15.9 – 32.3)	13	29.5	(17.6 – 45.1)	
Positive	70.3	77	74.0	(64.6 – 81.7)	27	61.4	(45.8 – 74.9)	
Missing		< 5			< 5			
Career								0.55
Negative	14.0	16	16.0	(10.0 – 24.7)	< 5	9.3	(3.4 – 23.1)	
No influence	25.2	24	24.0	(16.5 – 33.5)	12	27.9	(16.2 – 43.7)	
Positive	60.8	60	60.0	(50.0 – 69.3)	27	62.8	(47.0 – 76.3)	
Missing		7			< 5			

* Only asked of spouses/partners who have children with ADF member (All n = 152; Current n = 86; Ex-serving n = 32).
Note: 95% CI = 95% confidence interval.

Appendix E Effects of military service, perceptions of adult children

**Table E.1 Effect of military service on ADF members (adult children perspectives),
stratified by military status of ADF member**

Measure	Military status of ADF member							p-value
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their partner								0.02
Negative	40.7	14	30.4	(18.6 – 45.7)	21	52.5	(36.6 – 67.9)	
No influence	20.9	8	17.4	(8.7 – 31.7)	10	25.0	(13.6 – 41.3)	
Positive	38.4	24	52.2	(37.4 – 66.6)	9	22.5	(11.8 – 38.7)	
Missing		8			8			
Relationships with other immediate family								0.58
Negative	27.1	12	27.9	(16.2 – 43.7)	11	26.2	(14.8 – 42.1)	
No influence	40.0	15	34.9	(21.8 – 50.7)	19	45.2	(30.5 – 60.9)	
Positive	32.9	16	37.2	(23.7 – 53.0)	12	28.6	(16.6 – 44.6)	
Missing		11			6			
Relationships with their wider family								0.50
Negative	24.7	10	24.4	(13.3 – 40.4)	10	25.0	(13.6 – 41.3)	
No influence	42.0	15	36.6	(22.9 – 52.8)	19	47.5	(32.1 – 63.4)	
Positive	33.3	16	39.0	(24.9 – 55.2)	11	27.5	(15.5 – 43.9)	
Missing		13			8			
Relationships with their friends								0.17
Negative	10.5	< 5	4.7	(1.1 – 17.6)	7	16.3	(7.7 – 31.1)	
No influence	29.1	12	27.9	(16.2 – 43.7)	13	30.2	(18.0 – 46.1)	
Positive	60.5	29	67.4	(51.6 – 80.1)	23	53.5	(38.1 – 68.2)	
Missing		11			5			
Employment								0.08
Negative	10.6	< 5	6.0	(1.9 – 17.6)	7	15.9	(7.5 – 30.5)	
No influence	19.1	7	14.0	(6.6 – 27.1)	11	25.0	(14.1 – 40.4)	
Positive	70.2	40	80.0	(66.1 – 89.1)	26	59.1	(43.6 – 73.0)	
Missing		< 5			< 5			
Physical health								0.03
Negative	31.2	9	19.1	(10.0 – 33.5)	20	43.5	(29.6 – 58.5)	
No influence	8.6	< 5	8.5	(3.1 – 21.2)	< 5	8.7	(3.2 – 21.7)	
Positive	60.2	34	72.3	(57.4 – 83.5)	22	47.8	(33.4 – 62.6)	
Missing		7			< 5			

Measure	Military status of ADF member							
	All (n = 102)	Current (n = 54)			Ex-serving (n = 48)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Mental health								0.006
Negative	42.0	13	30.2	(18.0 – 46.1)	21	55.3	(38.7 – 70.7)	
No influence	24.7	9	20.9	(11.0 – 36.3)	11	28.9	(16.3 – 45.9)	
Positive	33.3	21	48.8	(33.9 – 64.0)	6	15.8	(7.0 – 31.9)	
Missing		11			10			
Financial situation								0.40
Negative	6.4	< 5	6.1	(1.9 – 18.0)	< 5	6.7	(2.1 – 19.4)	
No influence	14.9	5	10.2	(4.2 – 22.9)	9	20.0	(10.5 – 34.8)	
Positive	78.7	41	83.7	(70.0 – 91.8)	33	73.3	(58.0 – 84.5)	
Missing		5			< 5			
Career								0.15
Negative	6.2	< 5	3.8	(0.9 – 14.7)	< 5	9.1	(3.3 – 22.6)	
No influence	14.6	5	9.6	(3.9 – 21.6)	9	20.5	(10.7 – 35.5)	
Positive	79.2	45	86.5	(73.8 – 93.6)	31	70.5	(54.9 – 82.4)	
Missing		< 5			< 5			

Note: 95% CI = 95% confidence interval.

Table E.2 **Effect of ADF members' service on their civilian adult children, stratified by military status of ADF member**

Measure	Military status of ADF member							p-value
	All (n = 91)	Current (n = 47)			Ex-serving (n = 44)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with immediate family								0.27
Negative	22.6	10	23.3	(12.7 – 38.8)	9	22.0	(11.5 – 37.8)	
No influence	38.1	13	30.2	(18.0 – 46.1)	19	46.3	(31.3 – 62.1)	
Positive	39.3	20	46.5	(31.8 – 61.9)	13	31.7	(18.9 – 48.0)	
Missing		< 5			< 5			
Relationships with wider family								0.85
Negative	28.9	12	30.0	(17.4 – 46.5)	12	27.9	(16.2 – 43.7)	
No influence	50.6	19	47.5	(32.1 – 63.4)	23	53.5	(38.1 – 68.2)	
Positive	20.5	9	22.5	(11.8 – 38.7)	8	18.6	(9.3 – 33.7)	
Missing		7			< 5			
Relationships with their friends								0.05
Negative	27.4	14	34.1	(20.9 – 50.4)	9	20.9	(11.0 – 36.3)	
No influence	42.9	12	29.3	(17.0 – 45.5)	24	55.8	(40.3 – 70.3)	
Positive	29.8	15	36.6	(22.9 – 52.8)	10	23.3	(12.7 – 38.8)	
Missing		6			< 5			
Employment								0.65
Negative	11.9	6	14.6	(6.5 – 29.7)	< 5	9.3	(3.4 – 23.1)	
No influence	65.5	25	61.0	(44.8 – 75.1)	30	69.8	(53.9 – 82.0)	
Positive	22.6	10	24.4	(13.3 – 40.4)	9	20.9	(11.0 – 36.3)	
Missing		6			< 5			
Physical health								0.20
Negative	6.0	< 5	2.4	(0.3 – 16.6)	< 5	9.5	(3.5 – 23.6)	
No influence	71.1	28	68.3	(52.0 – 81.1)	31	73.8	(57.9 – 85.2)	
Positive	22.9	12	29.3	(17.0 – 45.5)	7	16.7	(7.9 – 31.8)	
Missing		6			< 5			
Mental health								0.64
Negative	33.7	14	33.3	(20.4 – 49.4)	14	34.1	(20.9 – 50.4)	
No influence	53.0	21	50.0	(34.7 – 65.3)	23	56.1	(40.2 – 70.9)	
Positive	13.3	7	16.7	(7.9 – 31.8)	< 5	9.8	(3.6 – 24.1)	
Missing		5			< 5			
Financial situation								0.86
Negative	3.7	< 5	2.5	(0.3 – 17.0)	< 5	4.8	(1.1 – 18.0)	
No influence	62.2	25	62.5	(46.1 – 76.5)	26	61.9	(45.9 – 75.7)	
Positive	34.1	14	35.0	(21.4 – 51.5)	14	33.3	(20.4 – 49.4)	
Missing		7			< 5			
Career								0.94
Negative	8.6	< 5	7.9	(2.4 – 22.8)	< 5	9.3	(3.4 – 23.1)	
No influence	66.7	25	65.8	(48.8 – 79.5)	29	67.4	(51.6 – 80.1)	
Positive	24.7	10	26.3	(14.4 – 43.2)	10	23.3	(12.7 – 38.8)	
Missing		9			< 5			

Note: 95% CI = 95% confidence interval.

Appendix F Effect of military service, perceptions of parents

**Table F.1 Effect of military service on ADF members (parents' perspectives), stratified by
military status of ADF member**

Measure	Military status of ADF member							p-value
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with their partner								0.01
Negative	36.9	44	33.1	(25.5 – 41.6)	28	45.2	(33.0 – 57.9)	
No influence	19.0	21	15.8	(10.5 – 23.1)	16	25.8	(16.2 – 38.4)	
Positive	44.1	68	51.1	(42.6 – 59.6)	18	29.0	(18.9 – 41.8)	
Missing		49			31			
Relationships with their other immediate family								0.008
Negative	17.9	22	12.6	(8.4 – 18.5)	25	28.1	(19.6 – 38.5)	
No influence	27.0	49	28.2	(21.9 – 35.4)	22	24.7	(16.7 – 34.9)	
Positive	55.1	103	59.2	(51.7 – 66.3)	42	47.2	(36.9 – 57.7)	
Missing		8			< 5			
Relationships with their wider family								0.002
Negative	11.7	11	6.7	(3.7 – 11.7)	18	21.7	(14.0 – 32.1)	
No influence	35.5	64	38.8	(31.6 – 46.5)	24	28.9	(20.0 – 39.8)	
Positive	52.8	90	54.5	(46.8 – 62.1)	41	49.4	(38.6 – 60.2)	
Missing		17			10			
Relationships with their friends								0.004
Negative	18.2	20	12.4	(8.1 – 18.5)	24	29.6	(20.6 – 40.7)	
No influence	22.7	37	23.0	(17.1 – 30.2)	18	22.2	(14.3 – 32.8)	
Positive	59.1	104	64.6	(56.8 – 71.7)	39	48.1	(37.3 – 59.2)	
Missing		21			12			
Employment								< 0.0001
Negative	17.4	11	7.2	(4.0 – 12.6)	31	35.2	(25.8 – 45.9)	
No influence	9.5	13	8.5	(5.0 – 14.2)	10	11.4	(6.1 – 20.1)	
Positive	73.0	129	84.3	(77.6 – 89.3)	47	53.4	(42.8 – 63.7)	
Missing		29			5			
Physical health								< 0.0001
Negative	29.3	31	18.2	(13.1 – 24.8)	45	50.6	(40.1 – 61.0)	
No influence	13.1	20	11.8	(7.7 – 17.6)	14	15.7	(9.4 – 25.0)	
Positive	57.5	119	70.0	(62.6 – 76.5)	30	33.7	(24.5 – 44.3)	
Missing		12			< 5			

Measure	Military status of ADF member							
	All (n = 275)	Current (n = 182)			Ex-serving (n = 93)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Mental health								< 0.0001
Negative	39.8	47	29.7	(23.1 – 37.4)	49	59.0	(48.0 – 69.3)	
No influence	14.9	22	13.9	(9.3 – 20.3)	14	16.9	(10.1 – 26.7)	
Positive	45.2	89	56.3	(48.4 – 63.9)	20	24.1	(16.0 – 34.7)	
Missing		24			10			
Financial situation								< 0.0001
Negative	13.2	9	5.2	(2.7 – 9.8)	25	29.4	(20.6 – 40.1)	
No influence	11.6	18	10.4	(6.6 – 16.0)	12	14.1	(8.1 – 23.5)	
Positive	75.2	146	84.4	(78.1 – 89.1)	48	56.5	(45.6 – 66.8)	
Missing		9			8			
Career								< 0.0001
Negative	16.9	15	8.7	(5.3 – 13.9)	29	33.0	(23.8 – 43.6)	
No influence	9.6	11	6.4	(3.5 – 11.2)	14	15.9	(9.6 – 25.3)	
Positive	73.6	147	85.0	(78.8 – 89.6)	45	51.1	(40.6 – 61.6)	
Missing		9			5			

Note: 95% CI = 95% confidence interval.

Table F.2 **Effect of ADF members' service on civilian parents, stratified by military status of ADF member**

Measure	Military status of ADF member							
	All (n = 232)	Current (n = 153)			Ex-serving (n = 79)			p-value
	%	n	%	(95% CI)	n	%	(95% CI)	
Relationships with immediate family								0.01
Negative	10.4	9	6.3	(3.3 – 11.7)	14	17.9	(10.8 – 28.3)	
No influence	53.8	77	53.8	(45.5 – 61.9)	42	53.8	(42.5 – 64.8)	
Positive	35.7	57	39.9	(32.1 – 48.2)	22	28.2	(19.2 – 39.4)	
Missing		10			< 5			
Relationships with their wider family								0.003
Negative	5.5	< 5	2.1	(0.7 – 6.5)	9	11.8	(6.2 – 21.5)	
No influence	61.8	85	60.3	(51.9 – 68.1)	49	64.5	(52.9 – 74.6)	
Positive	32.7	53	37.6	(29.9 – 46.0)	18	23.7	(15.3 – 34.8)	
Missing		12			< 5			
Relationships with their friends								0.16
Negative	4.7	< 5	2.9	(1.1 – 7.5)	6	8.1	(3.6 – 17.2)	
No influence	60.6	83	59.7	(51.3 – 67.6)	46	62.2	(50.4 – 72.7)	
Positive	34.7	52	37.4	(29.7 – 45.8)	22	29.7	(20.3 – 41.3)	
Missing		14			5			
Employment								0.02
Negative	6.1	< 5	2.4	(0.8 – 7.3)	9	12.5	(6.5 – 22.6)	
No influence	79.6	102	82.3	(74.4 – 88.1)	54	75.0	(63.5 – 83.8)	
Positive	14.3	19	15.3	(9.9 – 22.9)	9	12.5	(6.5 – 22.6)	
Missing		29			7			
Physical health								0.005
Negative	14.3	11	8.3	(4.6 – 14.4)	19	24.7	(16.2 – 35.8)	
No influence	70.0	99	74.4	(66.2 – 81.2)	48	62.3	(50.8 – 72.6)	
Positive	15.7	23	17.3	(11.7 – 24.8)	10	13.0	(7.0 – 22.7)	
Missing		20			< 5			
Mental health								0.002
Negative	24.9	24	17.1	(11.7 – 24.4)	30	39.0	(28.5 – 50.5)	
No influence	58.1	89	63.6	(55.2 – 71.2)	37	48.1	(36.9 – 59.4)	
Positive	17.1	27	19.3	(13.5 – 26.8)	10	13.0	(7.0 – 22.7)	
Missing		13			< 5			
Financial situation								0.004
Negative	8.4	5	3.9	(1.6 – 9.1)	12	16.2	(9.3 – 26.7)	
No influence	76.2	99	77.3	(69.2 – 83.9)	55	74.3	(62.9 – 83.2)	
Positive	15.3	24	18.8	(12.8 – 26.6)	7	9.5	(4.5 – 18.8)	
Missing		25			5			
Career								0.009
Negative	4.1	< 5	0.8	(0.1 – 5.7)	7	9.9	(4.7 – 19.6)	
No influence	86.6	111	90.2	(83.5 – 94.4)	57	80.3	(69.1 – 88.1)	
Positive	9.3	11	8.9	(5.0 – 15.5)	7	9.9	(4.7 – 19.6)	
Missing		30			8			

Note: 95% CI = 95% confidence interval.

Appendix G FWS and MHWTS respondent measures by mental health outcomes

Table G.1 FWS respondent and ADF member measures, stratified by FWS respondents' psychological distress

Measure	High psychological distress (n = 191)			Not high on psychological distress (n = 924)		
	n	%	(95% CI)	n	%	(95% CI)
FWS RESPONDENT						
Relationship to ADF member						
Spouse/partner	132	69.1	(62.1 – 75.3)	674	72.9	(70.0 – 75.7)
Parent	33	17.3	(12.5 – 23.4)	187	20.2	(17.8 – 23.0)
Adult child aged 18+	26	13.6	(9.4 – 19.3)	63	6.8	(5.4 – 8.6)
Education						
University degree	61	31.9	(25.7 – 38.9)	410	44.4	(41.2 – 47.6)
Certificate/diploma	80	41.9	(35.0 – 49.1)	307	33.2	(30.3 – 36.3)
Primary/secondary school	50	26.2	(20.4 – 32.9)	207	22.4	(19.8 – 25.2)
Poor physical health	69	36.1	(29.6 – 43.2)	72	7.8	(6.2 – 9.7)
5+ people in household	23	12.0	(8.1 – 17.5)	131	14.2	(12.1 – 16.6)
Unemployed	74	38.7	(32.0 – 45.9)	305	33.0	(30.0 – 36.1)
Is/Was an ADF member	45	23.6	(18.0 – 30.2)	142	15.4	(13.2 – 17.8)
ADF MEMBER						
Military status						
Current Serving	123	64.4	(57.3 – 70.9)	636	68.8	(65.8 – 71.7)
Active reservist	19	9.9	(6.4 – 15.1)	95	10.3	(8.5 – 12.4)
Inactive reservist	19	9.9	(6.4 – 15.1)	93	10.1	(8.3 – 12.2)
Discharged from ADF	30	15.7	(11.2 – 21.6)	100	10.8	(9.0 – 13.0)
Rank						
Commissioned Officer	71	37.2	(30.6 – 44.3)	478	51.7	(48.5 – 54.9)
Non-commissioned Officer	95	49.7	(42.6 – 56.9)	383	41.5	(38.3 – 44.7)
Other rank	25	13.1	(9.0 – 18.7)	63	6.8	(5.4 – 8.6)
Service type						
Navy	38	19.9	(14.8 – 26.2)	203	22.0	(19.4 – 24.8)
Army	92	48.2	(41.1 – 55.3)	415	44.9	(41.7 – 48.1)
Air Force	61	31.9	(25.7 – 38.9)	306	33.1	(30.2 – 36.2)
Years served in ADF (mean, SE)	19.3	0.7	(17.9 – 20.8)	18.8	0.3	(18.2 – 19.5)
Never deployed	18	9.4	(6.0 – 14.5)	101	10.9	(9.1 – 13.1)
Medically unfit for service	46	24.1	(18.5 – 30.7)	172	18.6	(16.2 – 21.3)

Measure	High psychological distress (n = 191)			Not high on psychological distress (n = 924)		
	n	%	(95% CI)	n	%	(95% CI)
Mental and physical wellbeing						
Neither problem	106	55.5	(48.3 – 62.5)	633	68.5	(65.4 – 71.4)
Poor physical health	27	14.1	(9.8 – 19.9)	107	11.6	(9.7 – 13.8)
High psychological distress	17	8.9	(5.6 – 13.9)	67	7.3	(5.7 – 9.1)
Poor physical health and high psychological distress	41	21.5	(16.2 – 27.9)	117	12.7	(10.7 – 15.0)
Problem drinking	44	23.0	(17.6 – 29.6)	219	23.7	(21.1 – 26.6)
Number of traumas in lifetime (mean, SE)	3.5	0.2	(3.1 – 4.0)	3.2	0.1	(3.0 – 3.4)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Table G.2 FWS respondent and ADF member measures, stratified by FWS respondents' high levels of posttraumatic stress disorder (PTSD) symptoms

Measure	High levels of PTSD symptoms (n = 99)			No high levels of PTSD symptoms (n = 1,018)		
	n	%	(95% CI)	n	%	(95% CI)
FWS RESPONDENT						
Relationship to ADF member						
Spouse/partner	62	62.6	(52.5 – 71.7)	748	73.5	(70.7 – 76.1)
Parent	27	27.3	(19.3 – 37.0)	191	18.8	(16.5 – 21.3)
Adult child aged 18+	10	10.1	(5.5 – 17.9)	79	7.8	(6.3 – 9.6)
Education						
University degree	32	32.3	(23.7 – 42.3)	440	43.2	(40.2 – 46.3)
Certificate/diploma	47	47.5	(37.7 – 57.5)	339	33.3	(30.5 – 36.3)
Primary/secondary school	20	20.2	(13.3 – 29.4)	239	23.5	(21.0 – 26.2)
Poor physical health	38	38.4	(29.2 – 48.5)	102	10.0	(8.3 – 12.0)
5+ people in household	11	11.1	(6.2 – 19.1)	143	14.0	(12.0 – 16.3)
Unemployed	35	35.4	(26.4 – 45.4)	345	33.9	(31.0 – 36.9)
Is/Was an ADF member	27	27.3	(19.3 – 37.0)	159	15.6	(13.5 – 18.0)
ADF MEMBER						
Military status						
Current serving	64	64.6	(54.6 – 73.6)	698	68.6	(65.6 – 71.3)
Active reservist	9	9.1	(4.7 – 16.7)	105	10.3	(8.6 – 12.3)
Inactive reservist	7	7.1	(3.4 – 14.3)	104	10.2	(8.5 – 12.2)
Discharged from ADF	19	19.2	(12.5 – 28.3)	111	10.9	(9.1 – 13.0)
Rank						
Commissioned Officer	37	37.4	(28.3 – 47.5)	514	50.5	(47.4 – 53.6)
Non-commissioned Officer	48	48.5	(38.7 – 58.4)	430	42.2	(39.2 – 45.3)
Other rank	14	14.1	(8.5 – 22.6)	74	7.3	(5.8 – 9.0)
Service						
Navy	35	35.4	(26.4 – 45.4)	208	20.4	(18.1 – 23.0)
Army	39	39.4	(30.1 – 49.5)	468	46.0	(42.9 – 49.1)
Air Force	25	25.3	(17.6 – 34.9)	342	33.6	(30.8 – 36.6)
Years served in ADF (mean, SE)	16.9	1.0	(14.9 – 18.8)	19.1	0.3	(18.5 – 19.7)
Never deployed	5	5.1	(2.1 – 11.7)	114	11.2	(9.4 – 13.3)
Medically unfit for service	24	24.2	(16.7 – 33.8)	194	19.1	(16.8 – 21.6)
Mental and physical wellbeing						
Neither problem	57	57.6	(47.5 – 67.1)	685	67.3	(64.3 – 70.1)
Poor physical health	11	11.1	(6.2 – 19.1)	124	12.2	(10.3 – 14.3)
High psychological distress	9	9.1	(4.7 – 16.7)	73	7.2	(5.7 – 8.9)
Poor physical health and high psychological distress	22	22.2	(15.0 – 31.6)	136	13.4	(11.4 – 15.6)
Problem drinking	21	21.2	(14.2 – 30.5)	239	23.5	(21.0 – 26.2)
Number of traumas (mean, SE)	3.3	0.3	(2.7 – 3.9)	3.3	0.1	(3.1 – 3.4)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Table G.3 FWS respondent and ADF member measures, stratified by FWS respondents' problem drinking

Measure	Problem drinking (n = 113)			No problem drinking (n = 1,011)		
	n	%	(95% CI)	n	%	(95% CI)
FWS RESPONDENT						
Relationship to ADF member						
Spouse/partner	78	69.0	(59.8 – 77.0)	733	72.5	(69.7 – 75.2)
Parent	18	15.9	(10.2 – 24.0)	204	20.2	(17.8 – 22.8)
Adult child aged 18+	17	15.0	(9.5 – 23.0)	74	7.3	(5.9 – 9.1)
Education						
University degree	38	33.6	(25.4 – 43.0)	437	43.2	(40.2 – 46.3)
Certificate/diploma	49	43.4	(34.4 – 52.8)	341	33.7	(30.9 – 36.7)
Primary/secondary school	26	23.0	(16.1 – 31.8)	233	23.0	(20.5 – 25.7)
Poor physical health	27	23.9	(16.8 – 32.8)	115	11.4	(9.6 – 13.5)
5+ people in household	10	8.8	(4.8 – 15.8)	145	14.3	(12.3 – 16.6)
Unemployed	33	29.2	(21.5 – 38.4)	345	34.1	(31.3 – 37.1)
Is/Was an ADF member	24	21.2	(14.6 – 29.9)	165	16.3	(14.2 – 18.7)
ADF MEMBER						
Military status						
Current serving	71	62.8	(53.4 – 71.3)	691	68.3	(65.4 – 71.1)
Active reservist	11	9.7	(5.4 – 16.9)	106	10.5	(8.7 – 12.5)
Inactive reservist	14	12.4	(7.4 – 20.0)	99	9.8	(8.1 – 11.8)
Discharged from ADF	17	15.0	(9.5 – 23.0)	115	11.4	(9.6 – 13.5)
Rank						
Commissioned Officer	51	45.1	(36.1 – 54.5)	501	49.6	(46.5 – 52.6)
Non-commissioned Officer	55	48.7	(39.5 – 58.0)	431	42.6	(39.6 – 45.7)
Other rank	7	6.2	(2.9 – 12.6)	79	7.8	(6.3 – 9.6)
Service						
Navy	27	23.9	(16.8 – 32.8)	213	21.1	(18.7 – 23.7)
Army	57	50.4	(41.2 – 59.7)	459	45.4	(42.3 – 48.5)
Air Force	29	25.7	(18.4 – 34.6)	339	33.5	(30.7 – 36.5)
Years served in ADF (mean, SE)	20.2	1.0	(18.3 – 22.1)	18.8	0.3	(18.2 – 19.4)
Never deployed	9	8.0	(4.2 – 14.7)	110	10.9	(9.1 – 13.0)
Medically unfit for service	27	23.9	(16.8 – 32.8)	199	19.7	(17.3 – 22.3)
Mental and physical wellbeing						
Neither problem	70	61.9	(52.5 – 70.5)	672	66.5	(63.5 – 69.3)
Poor physical health	14	12.4	(7.4 – 20.0)	122	12.1	(10.2 – 14.2)
High psychological distress	10	8.8	(4.8 – 15.8)	73	7.2	(5.8 – 9.0)
Poor physical health and high psychological distress	19	16.8	(10.9 – 25.0)	144	14.2	(12.2 – 16.5)
Problem drinking	38	33.6	(25.4 – 43.0)	230	22.7	(20.3 – 25.4)
Number of traumas (mean, SE)	3.7	0.3	(3.2 – 4.3)	3.2	0.1	(3.1 – 3.4)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Appendix H FWS and MHWTS respondent measures by couple relationship outcomes

Table H.1 Spouse/partner and ADF member measures, stratified by happiness in the couple relationship

Measure	Unhappy couple relationship (n = 175)			Happy couple relationship (n = 628)		
	n	%	(95% CI)	n	%	(95% CI)
SPOUSE/PARTNER						
Age (years)						
18 – < 38	46	26.3	(20.2 – 33.4)	212	33.8	(30.2 – 37.6)
38 – < 48	68	38.9	(31.9 – 46.3)	213	33.9	(30.3 – 37.7)
48+	61	34.9	(28.1 – 42.3)	203	32.3	(28.8 – 36.1)
Does not have a child with ADF member	28	16.0	(11.2 – 22.3)	121	19.3	(16.4 – 22.6)
Education						
University degree	81	46.3	(39.0 – 53.8)	293	46.7	(42.8 – 50.6)
Certificate/diploma	59	33.7	(27.0 – 41.1)	217	34.6	(30.9 – 38.4)
Primary/secondary school	35	20.0	(14.7 – 26.7)	118	18.8	(15.9 – 22.0)
Mental and physical wellbeing						
Neither problem	106	60.6	(53.1 – 67.6)	507	80.7	(77.4 – 83.6)
Poor physical health	15	8.6	(5.2 – 13.8)	44	7.0	(5.3 – 9.3)
High psychological distress	30	17.1	(12.2 – 23.5)	49	7.8	(5.9 – 10.2)
Poor physical health and high psychological distress	24	13.7	(9.3 – 19.7)	28	4.5	(3.1 – 6.4)
5+ people in household	29	16.6	(11.7 – 22.9)	109	17.4	(14.6 – 20.5)
Unemployed	56	32.0	(25.5 – 39.3)	200	31.8	(28.3 – 35.6)
Is/Was an ADF member	34	19.4	(14.2 – 26.0)	107	17.0	(14.3 – 20.2)
ADF MEMBER						
Has transitioned	61	34.9	(28.1 – 42.3)	187	29.8	(26.3 – 33.5)
Rank						
Commissioned Officer	75	42.9	(35.7 – 50.4)	314	50.0	(46.1 – 53.9)
Non-commissioned Officer	86	49.1	(41.7 – 56.6)	274	43.6	(39.8 – 47.6)
Other rank	14	8.0	(4.8 – 13.1)	40	6.4	(4.7 – 8.6)
Service						
Navy	31	17.7	(12.7 – 24.2)	136	21.7	(18.6 – 25.1)
Army	89	50.9	(43.4 – 58.3)	279	44.4	(40.6 – 48.3)
Air Force	55	31.4	(24.9 – 38.7)	213	33.9	(30.3 – 37.7)
Years served in ADF (mean, SE)	19.6	0.7	(18.2 – 21.0)	19.8	0.4	(19.0 – 20.6)
Never deployed	12	6.9	(3.9 – 11.7)	66	10.5	(8.3 – 13.2)
Medically unfit for service	38	21.7	(16.2 – 28.5)	100	15.9	(13.3 – 19.0)

Measure	Unhappy couple relationship (n = 175)			Happy couple relationship (n = 628)		
	n	%	(95% CI)	n	%	(95% CI)
Mental and physical wellbeing						
Neither problem	104	59.4	(51.9 – 66.5)	427	68.0	(64.2 – 71.5)
Poor physical health	23	13.1	(8.9 – 19.1)	77	12.3	(9.9 – 15.1)
High psychological distress	13	7.4	(4.3 – 12.4)	52	8.3	(6.4 – 10.7)
Poor physical health and high psychological distress	35	20.0	(14.7 – 26.7)	72	11.5	(9.2 – 14.2)
Problem drinking	45	25.7	(19.7 – 32.8)	141	22.5	(19.3 – 25.9)
Number of traumas (mean, SE)	3.7	0.2	(3.2 – 4.1)	3.3	0.1	(3.1 – 3.5)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Table H.2 Couple relationship quality by spouse/partner and ADF member measures

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Age (years)				
18 – < 38	258	4.22	0.04	(4.14 – 4.30)
38 – < 48	281	4.13	0.04	(4.04 – 4.21)
48+	264	4.20	0.05	(4.11 – 4.30)
Does not have a child with ADF member	149	4.29	0.06	(4.18 – 4.40)
Education				
University degree	374	4.16	0.04	(4.09 – 4.23)
Certificate/diploma	276	4.20	0.05	(4.11 – 4.29)
Primary/secondary school	153	4.21	0.06	(4.10 – 4.33)
Mental and physical wellbeing				
Neither problem	613	4.29	0.03	(4.23 – 4.34)
Poor physical health	59	4.15	0.09	(3.98 – 4.33)
High psychological distress	79	3.80	0.10	(3.60 – 3.99)
Poor physical health and high psychological distress	52	3.58	0.12	(3.34 – 3.81)
5+ people in household	138	4.16	0.06	(4.04 – 4.28)
Unemployed	256	4.19	0.05	(4.10 – 4.28)
Is/Was an ADF member	141	4.16	0.06	(4.04 – 4.28)
ADF MEMBER				
Has transitioned	248	4.07	0.05	(3.98 – 4.16)
Rank				
Commissioned Officer	389	4.30	0.03	(4.24 – 4.37)
Non-commissioned Officer	360	4.09	0.04	(4.01 – 4.17)
Other rank	54	3.93	0.10	(3.73 – 4.13)
Service				
Navy	167	4.26	0.05	(4.16 – 4.37)
Army	368	4.14	0.04	(4.07 – 4.22)
Air Force	268	4.19	0.04	(4.10 – 4.27)
Never deployed	78	4.35	0.07	(4.20 – 4.49)
Medically unfit for service	138	3.98	0.06	(3.86 – 4.10)
Mental and physical wellbeing				
Neither problem	531	4.28	0.03	(4.22 – 4.34)
Poor physical health	100	4.11	0.07	(3.96 – 4.26)
High psychological distress	65	4.06	0.10	(3.86 – 4.25)
Poor physical health and high psychological distress	107	3.84	0.07	(3.70 – 3.99)
Problem drinking	186	4.01	0.06	(3.90 – 4.12)

Note: 95% CI = 95% confidence interval. SE = standard error.

Table H.3 Spouse/partner and ADF member measures, stratified by the occurrence of abuse at some stage of the couple relationship

Measure	Abuse in relationship (n = 38)			No abuse in relationship (n = 759)		
	n	%	(95% CI)	n	%	(95% CI)
SPOUSE/PARTNER						
Age (years)						
18 – < 38	11	28.9	(16.3 – 45.9)	245	32.3	(29.0 – 35.7)
38 – < 48	13	34.2	(20.5 – 51.2)	266	35.0	(31.7 – 38.5)
48+	14	36.8	(22.6 – 53.8)	248	32.7	(29.4 – 36.1)
Does not have a child with ADF member	7	18.4	(8.7 – 34.8)	140	18.4	(15.8 – 21.4)
Education						
University degree	19	50.0	(33.9 – 66.1)	353	46.5	(43.0 – 50.1)
Certificate/diploma	12	31.6	(18.4 – 48.6)	263	34.7	(31.3 – 38.1)
Primary/secondary school	7	18.4	(8.7 – 34.8)	143	18.8	(16.2 – 21.8)
Mental and physical wellbeing						
Neither problem	17	44.7	(29.3 – 61.3)	593	78.1	(75.0 – 80.9)
Poor physical health	4	10.5	(3.8 – 25.8)	55	7.2	(5.6 – 9.3)
High psychological distress	7	18.4	(8.7 – 34.8)	70	9.2	(7.4 – 11.5)
Poor physical health and high psychological distress	10	26.3	(14.4 – 43.2)	41	5.4	(4.0 – 7.3)
5+ people in household	5	13.2	(5.4 – 28.9)	132	17.4	(14.9 – 20.3)
Unemployed	17	44.7	(29.3 – 61.3)	235	31.0	(27.8 – 34.4)
Is/Was an ADF member	6	15.8	(7.0 – 31.9)	134	17.7	(15.1 – 20.5)
ADF MEMBER						
Has transitioned	21	55.3	(38.7 – 70.7)	225	29.6	(26.5 – 33.0)
Rank						
Commissioned Officer	14	36.8	(22.6 – 53.8)	372	49.0	(45.5 – 52.6)
Non-commissioned Officer	18	47.4	(31.6 – 63.7)	339	44.7	(41.2 – 48.2)
Other rank	6	15.8	(7.0 – 31.9)	48	6.3	(4.8 – 8.3)
Service						
Navy	6	15.8	(7.0 – 31.9)	160	21.1	(18.3 – 24.1)
Army	22	57.9	(41.2 – 73.0)	344	45.3	(41.8 – 48.9)
Air Force	10	26.3	(14.4 – 43.2)	255	33.6	(30.3 – 37.0)
Years served in ADF (mean, SE)	16.7	1.6	(13.5 – 19.8)	19.9	0.3	(19.2 – 20.5)
Never deployed	< 5	5.3	(1.2 – 19.8)	75	9.9	(7.9 – 12.2)
Medically unfit for service	12	31.6	(18.4 – 48.6)	125	16.5	(14.0 – 19.3)
Mental and physical wellbeing						
Neither problem	17	44.7	(29.3 – 61.3)	511	67.3	(63.9 – 70.6)
Poor physical health	< 5	7.9	(2.4 – 22.8)	96	12.6	(10.5 – 15.2)
High psychological distress	< 5	10.5	(3.8 – 25.8)	61	8.0	(6.3 – 10.2)
Poor physical health and high psychological distress	14	36.8	(22.6 – 53.8)	91	12.0	(9.9 – 14.5)
Problem drinking	15	39.5	(24.8 – 56.3)	169	22.3	(19.4 – 25.4)
Number of traumas (mean, SE)	4.0	0.5	(3.1 – 5.0)	3.4	0.1	(3.2 – 3.6)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Appendix I FWS respondent and ADF member measures by parenting practices outcomes

Table I.1 Parenting self-efficacy by spouse/partner and ADF member measures (n = 428)

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Parent's age (years)				
18 – < 38	149	3.99	0.08	(3.84 – 4.14)
38 – < 48	216	4.00	0.06	(3.89 – 4.12)
48+	63	4.19	0.12	(3.96 – 4.42)
Education				
University degree	213	4.04	0.06	(3.92 – 4.16)
Below university degree	215	4.01	0.06	(3.89 – 4.13)
Mental and physical wellbeing				
Neither problem	330	4.09	0.05	(4.00 – 4.19)
Poor physical health	32	4.09	0.14	(3.81 – 4.37)
High psychological distress	39	3.72	0.15	(3.42 – 4.01)
Poor physical health and high psychological distress	27	3.59	0.18	(3.22 – 3.96)
5+ people in household	119	4.08	0.07	(3.93 – 4.22)
Unemployed	136	3.96	0.08	(3.81 – 4.12)
Is/Was an ADF member	80	4.03	0.10	(3.83 – 4.22)
ADF MEMBER				
Has transitioned	105	4.00	0.09	(3.82 – 4.18)
Rank				
Commissioned Officer	208	4.12	0.06	(4.00 – 4.23)
Non-commissioned Officer / Other rank	220	3.95	0.06	(3.82 – 4.07)
Service				
Navy	81	3.95	0.10	(3.76 – 4.14)
Army	206	4.08	0.06	(3.96 – 4.20)
Air Force	141	4.00	0.08	(3.85 – 4.15)
Never deployed	42	3.69	0.15	(3.39 – 3.99)
Medically unfit for service	59	4.12	0.11	(3.91 – 4.33)
Mental and physical wellbeing				
Neither problem	294	4.06	0.05	(3.96 – 4.16)
Poor physical health	57	3.86	0.13	(3.59 – 4.13)
High psychological distress	28	4.32	0.14	(4.04 – 4.60)
Poor physical health and high psychological distress	49	3.88	0.12	(3.63 – 4.12)
Problem drinking	86	3.87	0.09	(3.69 – 4.06)

Note: 95% CI = 95% confidence interval. SE = standard error.

Table I.2 Parenting consistency by spouse/partner and ADF member measures (n = 420)

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Parent's age (years)				
18 – < 38	149	4.23	0.05	(4.13 – 4.33)
38 – < 48	216	4.22	0.05	(4.13 – 4.31)
48+	63	4.17	0.08	(4.01 – 4.34)
Education				
University degree	213	4.28	0.04	(4.20 – 4.36)
Below university degree	215	4.15	0.05	(4.06 – 4.25)
Mental and physical wellbeing				
Neither problem	330	4.28	0.03	(4.21 – 4.34)
Poor physical health	32	4.12	0.12	(3.87 – 4.36)
High psychological distress	39	3.97	0.13	(3.72 – 4.22)
Poor physical health and high psychological distress	27	3.95	0.15	(3.64 – 4.25)
5+ people in household	119	4.28	0.05	(4.18 – 4.39)
Unemployed	136	4.25	0.05	(4.15 – 4.36)
Is/Was an ADF member	80	4.15	0.08	(3.99 – 4.30)
ADF MEMBER				
Has transitioned	105	4.09	0.07	(3.95 – 4.23)
Rank				
Commissioned Officer	208	4.33	0.04	(4.25 – 4.41)
Non-commissioned Officer / Other rank	220	4.11	0.05	(4.01 – 4.21)
Service				
Navy	81	4.25	0.07	(4.12 – 4.38)
Army	206	4.22	0.05	(4.12 – 4.31)
Air Force	141	4.19	0.06	(4.08 – 4.30)
Never deployed	42	4.27	0.08	(4.10 – 4.43)
Medically unfit for service	59	4.13	0.09	(3.96 – 4.31)
Mental and physical wellbeing				
Neither problem	294	4.25	0.04	(4.18 – 4.32)
Poor physical health	57	4.11	0.10	(3.90 – 4.31)
High psychological distress	28	4.44	0.11	(4.21 – 4.68)
Poor physical health and high psychological distress	49	3.99	0.10	(3.79 – 4.19)
Problem drinking	86	4.06	0.08	(3.91 – 4.21)

Note: 95% CI = 95% confidence interval. SE = standard error.

Table I.3 Parenting hostility by spouse/partner and ADF member measures (n = 422)

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Parent's age (years)				
18 – < 38	149	1.92	0.05	(1.83 – 2.01)
38 – < 48	216	1.87	0.04	(1.80 – 1.95)
48+	63	1.66	0.07	(1.53 – 1.80)
Education				
University degree	213	1.85	0.04	(1.78 – 1.92)
Below university degree	215	1.87	0.04	(1.79 – 1.95)
Mental and physical wellbeing				
Neither problem	330	1.82	0.03	(1.76 – 1.87)
Poor physical health	32	1.87	0.11	(1.65 – 2.09)
High psychological distress	39	1.97	0.09	(1.78 – 2.16)
Poor physical health and high psychological distress	27	2.24	0.12	(1.99 – 2.50)
5+ people in household	119	1.88	0.05	(1.78 – 1.97)
Unemployed	136	1.92	0.05	(1.83 – 2.02)
Is/Was an ADF member	80	1.87	0.07	(1.74 – 2.00)
ADF MEMBER				
Has transitioned	105	1.91	0.06	(1.79 – 2.04)
Rank				
Commissioned Officer	208	1.81	0.03	(1.74 – 1.87)
Non-commissioned Officer / Other rank	220	1.91	0.04	(1.83 – 1.99)
Service				
Navy	81	1.86	0.06	(1.73 – 1.98)
Army	206	1.89	0.04	(1.82 – 1.97)
Air Force	141	1.81	0.04	(1.72 – 1.90)
Never deployed	42	1.90	0.09	(1.72 – 2.07)
Medically unfit for service	59	1.88	0.07	(1.73 – 2.03)
Mental and physical wellbeing				
Neither problem	294	1.85	0.03	(1.79 – 1.91)
Poor physical health	57	1.94	0.08	(1.78 – 2.11)
High psychological distress	28	1.61	0.09	(1.43 – 1.79)
Poor physical health and high psychological distress	49	1.94	0.10	(1.75 – 2.14)
Problem drinking	86	1.97	0.07	(1.84 – 2.10)

Note: 95% CI = 95% confidence interval. SE = standard error.

Table I.4 Parenting use of reasoning by spouse/partner and ADF member measures (n = 420)

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Parent's age (years)				
18 – < 38	149	4.23	0.06	(4.12 – 4.34)
38 – < 48	216	4.19	0.05	(4.09 – 4.28)
48+	63	4.19	0.11	(3.97 – 4.40)
Education				
University degree	213	4.26	0.04	(4.17 – 4.34)
Below university degree	215	4.14	0.05	(4.04 – 4.25)
Mental and physical wellbeing				
Neither problem	330	4.24	0.04	(4.17 – 4.32)
Poor physical health	32	4.07	0.15	(3.76 – 4.38)
High psychological distress	39	3.96	0.14	(3.68 – 4.23)
Poor physical health and high psychological distress	27	4.20	0.13	(3.93 – 4.46)
5+ people in household	119	4.21	0.06	(4.10 – 4.33)
Unemployed	136	4.16	0.06	(4.04 – 4.28)
Is/Was an ADF member	80	4.08	0.09	(3.90 – 4.27)
ADF MEMBER				
Has transitioned	105	4.10	0.08	(3.94 – 4.26)
Rank				
Commissioned Officer	208	4.27	0.05	(4.18 – 4.36)
Non-commissioned Officer / Other rank	220	4.13	0.05	(4.03 – 4.23)
Service				
Navy	81	4.20	0.07	(4.05 – 4.35)
Army	206	4.23	0.05	(4.14 – 4.33)
Air Force	141	4.15	0.06	(4.02 – 4.28)
Never deployed	42	4.02	0.13	(3.74 – 4.29)
Medically unfit for service	59	4.03	0.11	(3.82 – 4.24)
Mental and physical wellbeing				
Neither problem	294	4.25	0.04	(4.17 – 4.32)
Poor physical health	57	4.08	0.11	(3.85 – 4.31)
High psychological distress	28	4.42	0.11	(4.20 – 4.64)
Poor physical health and high psychological distress	49	3.92	0.13	(3.67 – 4.18)
Problem drinking	86	4.12	0.07	(3.97 – 4.27)

Note: 95% CI = 95% confidence interval. SE = standard error.

Table I.5 Parenting warmth by spouse/partner and ADF member measures (n = 427)

Measure	n	Mean	SE	(95% CI)
SPOUSE/PARTNER				
Parent's age (years)				
18 – < 38	149	4.30	0.05	(4.20 – 4.41)
38 – < 48	216	4.19	0.05	(4.09 – 4.28)
48+	63	4.16	0.10	(3.96 – 4.36)
Education				
University degree	213	4.20	0.05	(4.11 – 4.29)
Below university degree	215	4.25	0.05	(4.15 – 4.35)
Mental and physical wellbeing				
Neither problem	330	4.24	0.04	(4.17 – 4.32)
Poor physical health	32	4.32	0.11	(4.10 – 4.54)
High psychological distress	39	4.15	0.12	(3.91 – 4.38)
Poor physical health and high psychological distress	27	4.04	0.17	(3.70 – 4.38)
5+ people in household	119	4.05	0.07	(3.92 – 4.18)
Unemployed	136	4.25	0.06	(4.13 – 4.36)
Is/Was an ADF member	80	3.97	0.10	(3.77 – 4.16)
ADF MEMBER				
Has transitioned	105	4.15	0.08	(4.00 – 4.31)
Rank				
Commissioned Officer	208	4.21	0.05	(4.12 – 4.31)
Non-commissioned Officer / Other rank	220	4.24	0.05	(4.14 – 4.33)
Service				
Navy	81	4.21	0.08	(4.05 – 4.36)
Army	206	4.28	0.05	(4.18 – 4.37)
Air Force	141	4.16	0.06	(4.03 – 4.28)
Never deployed	42	4.10	0.12	(3.85 – 4.35)
Medically unfit for service	59	4.20	0.10	(3.99 – 4.41)
Mental and physical wellbeing				
Neither problem	294	4.25	0.04	(4.17 – 4.32)
Poor physical health	57	4.11	0.10	(3.90 – 4.31)
High psychological distress	28	4.65	0.09	(4.45 – 4.84)
Poor physical health and high psychological distress	49	4.00	0.13	(3.74 – 4.26)
Problem drinking	86	4.24	0.08	(4.08 – 4.40)

Note: 95% CI = 95% confidence interval. SE = standard error.

Appendix J FWS and MHWTS respondent measures by total behaviour problems in children aged 2 to 17 years

Table J.1 Spouse/partner and ADF member measures, stratified by child total behaviour problems

Measure	High levels of behaviour problems (n = 93)			Does not have high levels of behaviour problems (n = 326)		
	n	%	(95% CI)	n	%	(95% CI)
SPOUSE/PARTNER						
Parent's age (years)						
18 – < 38	29	31.2	(22.5 – 41.5)	117	35.9	(30.8 – 41.3)
38 – < 48	52	55.9	(45.5 – 65.8)	159	48.8	(43.4 – 54.2)
48+	12	12.9	(7.4 – 21.6)	50	15.3	(11.8 – 19.7)
Child's age (years; mean, SE)	9.7	0.4	(8.8 – 10.5)	9.0	0.3	(8.5 – 9.5)
Education: below university degree	61	65.6	(55.2 – 74.7)	148	45.4	(40.0 – 50.9)
Mental and physical wellbeing						
Neither problem	54	58.1	(47.6 – 67.8)	269	82.5	(78.0 – 86.3)
Poor physical health	11	11.8	(6.6 – 20.3)	20	6.1	(4.0 – 9.3)
High psychological distress	15	16.1	(9.9 – 25.2)	24	7.4	(5.0 – 10.8)
Poor physical health and high psychological distress	13	14.0	(8.2 – 22.8)	13	4.0	(2.3 – 6.8)
5+ people in household	24	25.8	(17.8 – 35.8)	94	28.8	(24.2 – 34.0)
Unemployed	35	37.6	(28.2 – 48.1)	95	29.1	(24.4 – 34.3)
Is/Was an ADF member	19	20.4	(13.3 – 30.0)	60	18.4	(14.5 – 23.0)
Parental consistency (mean, SE)	4.0	0.1	(3.8 – 4.1)	4.3	0.0	(4.2 – 4.4)
Parental hostility (mean, SE)	2.2	0.1	(2.1 – 2.4)	1.8	0.0	(1.7 – 1.8)
ADF MEMBER						
Has transitioned	19	20.4	(13.3 – 30.0)	84	25.8	(21.3 – 30.8)
Rank: Non-commissioned Officer / Other rank	62	66.7	(56.3 – 75.6)	153	46.9	(41.5 – 52.4)
Service						
Navy	19	20.4	(13.3 – 30.0)	61	18.7	(14.8 – 23.3)
Army	41	44.1	(34.2 – 54.5)	161	49.4	(44.0 – 54.8)
Air Force	33	35.5	(26.3 – 45.9)	104	31.9	(27.0 – 37.2)
Years served in ADF (mean, SE)	17.9	0.8	(16.3 – 19.4)	18.5	0.5	(17.6 – 19.4)
Never deployed	10	10.8	(5.8 – 19.0)	32	9.8	(7.0 – 13.6)
Medically unfit for service	11	11.8	(6.6 – 20.3)	46	14.1	(10.7 – 18.4)

Measure	High levels of behaviour problems (n = 93)			Does not have high levels of behaviour problems (n = 326)		
	n	%	(95% CI)	n	%	(95% CI)
Mental and physical wellbeing						
Neither problem	59	63.4	(53.0 – 72.7)	229	70.2	(65.0 – 75.0)
Poor physical health	16	17.2	(10.7 – 26.5)	39	12.0	(8.8 – 16.0)
High psychological distress	< 5	4.3	(1.6 – 11.1)	24	7.4	(5.0 – 10.8)
Poor physical health and high psychological distress	14	15.1	(9.0 – 24.0)	34	10.4	(7.5 – 14.3)
Problem drinking	24	25.8	(17.8 – 35.8)	59	18.1	(14.3 – 22.7)
Number of traumas (mean, SE)	2.8	0.2	(2.4 – 3.2)	3.2	0.2	(2.9 – 3.5)

Notes:

Estimates are number and percentage unless otherwise stated.

95% CI = 95% confidence interval. SE = standard error.

Acronyms and abbreviations

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
AUDIT	Alcohol Use Disorders Identification Test
AWLI	Australian Work and Life Index
BNLA	<i>Building a New Life in Australia: The Longitudinal Study of Humanitarian Migrants</i>
CI	confidence interval
DAR-5	Dimensions of Anger Reactions 5-item scale
Defence	Department of Defence
DVA	Department of Veterans' Affairs
FWS	Family Wellbeing Study
GAD-7	Generalised Anxiety Disorder 7-item scale
GP	general practitioner
HILDA	Household, Income and Labour Dynamics in Australia Survey
K10	Kessler Psychological Distress 10-item scale
LSAC	<i>Growing up in Australia: The Longitudinal Study of Australian Children</i>
LSIC	<i>Footprints in Time: The Longitudinal Study of Indigenous Children</i>
MHWTS	Mental Health and Wellbeing Transition Study
MVRSR	Military and Veteran Research Study Roll
OR	odds ratio
p	probability
PCL-C	Posttraumatic Stress Disorder Checklist – civilian version

PHQ-9	Patient Health Questionnaire 9-item scale
Programme	Transition and Wellbeing Research Programme
PTSD	posttraumatic stress disorder
SD	standard deviation
SDQ	Strengths and Difficulties Questionnaire
SE	standard error
VVCS	Veterans and Veterans Families Counselling Service
VVFS	Vietnam Veterans Family Study

Glossary

ADF members. Current or Ex-Serving Australian Defence Force (ADF) members who took part in the Mental Health and Wellbeing Transition Study.

Current Serving. Individuals who were full-time serving members of the ADF at the time that the Mental Health and Wellbeing Transition Study was conducted in 2015.

Ex-Serving. Individuals who had left active full-time ADF service between 2010 and 2014. They include individuals who were active reservists, inactive reservists, or had transitioned to civilian life at the time that the Mental Health and Wellbeing Transition Study was conducted in 2015.

FWS respondents. Family members who participated in the Family Wellbeing Study (FWS).

Medical Employment Classification status. ADF members' medical fitness for service, a dichotomous variable derived from the Medical Employment Classification.

MHWTS respondents. Current Serving or Ex-Serving ADF members who participated in the Mental Health and Wellbeing Transition Study (MHWTS).

Military families. Families in which a family member is currently serving or has served in a nation's defence force.

Programme population. ADF members who were discharged from full-time active service between 2010 and 2014, either voluntarily or involuntarily (including those who had transitioned to civilian life; had become active or inactive reservists; or were Ab-initio reservists); and ADF members who were on full-time, active duty in 2015 who were recruited to the Transition and Wellbeing Research Programme.

Transition. The period following exit from service when ex-serving members are moving into civilian life.

Transitioned. Individuals who have recently exited from full-time active service.

References

- Acion, L., Ramirez, M. R., Jorge, R. E., & Arndt, S. (2013). Increased risk of alcohol and drug use among children from deployed military families. *Addiction, 108*(8), 1418–1425.
- Allen, E. S., Rhoades, G. K., Stanley, S. M., & Markman, H. J. (2010). Hitting home: Relationships between recent deployment, posttraumatic stress symptoms, and marital functioning for Army couples. *Journal of Family Psychology, 24*(3), 280–288.
- American Psychological Association Presidential Task Force on Military Deployment Services for Youth Families and Service Members. (2007). *The psychological needs of U.S. military service members and their families: A preliminary report*. Washington, DC: American Psychological Association.
- Anderson, J. R., Johnson, M. D., Goff, B. N., Cline, L. E., Lyon, S. E., & Gurss, H. (2011). Factors that differentiate distressed and nondistressed marriages in army soldiers. *Marriage and Family Review, 47*(7), 459–473.
- Armstrong, A., & Carroll, M. (2017). *Gambling activity in Australia: Findings from wave 15 of the Household, Income and Labour Dynamics in Australia (HILDA) Survey*. Melbourne: Australian Gambling Research Centre, Australian Institute of Family Studies.
- Artazcoz, L., Benach, J., Borrell, C., & Cortès, I. (2004). Unemployment and mental health: Understanding the interactions among gender, family roles, and social class. *American Journal of Public Health, 94*(1), 82–88.
- Astor, R. A. (2011). The need to support students from military families. *Education Week, 30*(33), 32–33.
- Atkins, S., Beach, R., Green, R., Newman, J., Raad, D., Valle, J., & Walters, J. (2014). *2012 Australian Defence Force Families Survey report*. Canberra: Directorate of Strategic People Research, Department of Defence.
- Australian Bureau of Statistics. (2008). *2007 National Survey of Mental Health and Wellbeing: Summary of results*. Cat. no. 4326.0. Canberra: ABS.
- Australian Bureau of Statistics. (2010). *Australian Social Trends December 2010*. Cat. no. 4102.0. Canberra: ABS.
- Australian Bureau of Statistics. (2011). *General Social Survey: Summary results*. Cat. no. 4159.0. Canberra, ABS.

- Australian Bureau of Statistics. (2014). *Personal Safety, Australia 2012*. Cat. no. 4906.0. Canberra: ABS.
- Australian Bureau of Statistics. (2015). *National Health Survey: First results 2014–15*. Cat no. 4364.0. Canberra: ABS.
- Australian Bureau of Statistics. (2016). *Education and Work, Australia, May 2016*. Cat. no. 6227.0. Canberra: ABS.
- Australian Institute of Health and Welfare. (2014). *National Drug Strategy Household Survey detailed report 2013*. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
- Australian Institute of Health and Welfare. (2017). *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: In brief summary report*. Cat. no. PHE 213. Canberra: AIHW.
- Balfour, A., Morgan, M., & Vincent, C. (2012). *How couple relationships shape our world: Clinical practice, research, and policy perspectives*. London: Karnac Books.
- Barker, L. H., & Berry, K. D. (2009). Developmental issues impacting military families with young children during single and multiple deployments. *Military Medicine*, 174, 1033–1040.
- Barnes, J., & Stein, A. (2000). Effects of parental psychiatric and physical illness on child development. In M. G. Gelder, J. J. Lopez-Ibor, & N. C. Andreasen (Eds.), *New Oxford Textbook of Psychiatry* (pp. 1848–1854). Oxford: Oxford University Press.
- Barnes, V. A., Davis, H., & Treiber, F. A. (2007). Perceived stress, heart rate, and blood pressure among adolescents with family members deployed in Operation Iraqi Freedom. *Military Medicine*, 172(2), 40–43.
- Baxter, J., Gray, M., Hand, K., & Hayes, A. (2013). *Parental joblessness, financial disadvantage and the wellbeing of parents and children*. FaHCSIA Occasional Paper No. 48. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.
- Benes, F. (2001). The development of prefrontal cortex: The maturation of neurotransmitter systems and their interactions. In C. Nelson & M. Luciana (Eds.), *Handbook of developmental cognitive neuroscience* (pp. 79–105). Cambridge, MA: MIT Press.
- Bennetts Kneebone, L. (2014). *Financial hardship in Australia*. [Data highlight: No.1/2014]. Canberra: National Centre for Longitudinal Data, Department of Social Services.

- Bergman, J. S., Renshaw, K. D., Allen, E. S., Markman, H. J., & Stanley, S. M. (2014). Meaningfulness of service and marital satisfaction in army couples. *Journal of Family Psychology, 28*(5), 701–706.
- Berle, D., & Steel, Z. (2015). Families of returned defence force personnel: A changing landscape of challenges. *Australasian Psychiatry, 23*(4), 399–402.
- Biddle, D., Hawthorne, G., Forbes, G., & Coman, G. (2005). Problem gambling in Australian PTSD treatment-seeking veterans. *Journal of Traumatic Stress, 18*(6), 759–767.
- Black, M. C., & Merrick, M. T. (2013). *Prevalence of intimate partner violence, stalking, and sexual violence among active duty women and wives of active duty men: Comparisons with women in the U.S. general population, 2010*. Atlanta, GA: National Center for Injury Prevention and Control.
- Black, T., Westwood, M. J., & Sorsdal, M. N. (2007). From the front line to the front of the class: Counseling students who are military veterans. In J. A. Lippincott & R. B. Lippincott (Eds.), *Special populations in college counseling: A handbook for mental health professionals* (pp. 3–20). Alexandria, VA: American Counseling Association.
- Booth, A. L., & Kee, H. J. (2009). Birth order matters: The effect of family size and birth order on educational attainment. *Journal of Population Economics, 22*(2), 367–397.
- Booth, B., Segal, M. W., Bell, B. D., Martin, J. A., Ender, M. G., Rohall, D. E., & Nelson, J. (2007). *What we know about Army families: 2007 update*. Washington, DC: Department of Army Family and Morale, Welfare and Recreation Command.
- Bowling, U. B., & Sherman, M. D. (2008). Welcoming them home: Supporting service members and their families in navigating the tasks of reintegration. *Professional Psychology: Research and Practice, 39*(4), 451–458.
- Bradbard, D., Maury, R., Kimball, M., Wright, J., Elquist Lore, C., Levingston, K., Mannino White, A. (2014). *2014 Military Family Lifestyle Survey comprehensive report*. Department of Research and Policy in collaboration with the Institute of Veterans and Military Families, Syracuse University.
- Bradshaw, C. P., Sudhinaraset, M., Mmari, K., & Blum, R. (2010). School transitions among military adolescents: A qualitative study of stress and coping. *School Psychology Review, 39*, 84–105.
- Bray, R. M., Hourani, L. L., Olmsted, K. L., Witt, M., Brown, J. M., & Pemberton, M. R. (2006). *2005 Department of Defense survey of health related behaviors among military personnel*. [Report prepared for the Assistant Secretary of Defense (Health Affairs)]. North Carolina: Research Triangle Institute International.

- Bray, R. M., Hourani, L. L., Rae, K. L., Dever, J. A., Brown, J. M., Vincus, A. A., ... Vandermaas-Peeler, R. (2003). *2002 Department of Defense survey of health related behaviors among military personnel: Final report*. [Report prepared for the Assistant Secretary of Defense (Health Affairs)]. North Carolina: Research Triangle Institute International.
- Bray, R. M., Pemberton, M. R., Hourani, L., Witt, M., Rae Olmsted, C., Brown, J., ... Bradshaw, M. (2009). *2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program*. North Carolina: Research Triangle Institute International.
- Bray, R. M., Pemberton, M. R., Lane, M. E., Hourani, L. L., Mattiko, M. J., & Babeu, L. A. (2010). Substance use and mental health trends among U.S. military active duty personnel: Key findings from the 2008 DoD Health Behavior Survey. *Military Medicine*, 175(6), 390–399.
- Brown, J. B., Lent, B., Schmidt, G., & Sas, G. (2000). Application of the Woman Abuse Screening Tool (WAST) and WAST-short in the family practice setting. *Journal of Family Practice*, 49(10), 896–903.
- Brown, T., Wensing, E., & Department of Defence Directorate of People, Intelligence and Research. (2016). *ADF Families Survey: Absences and relocations*. Canberra: Department of Defence.
- Bubonya, M., Cobb-Clark, D., & Wooden, M. (2014). *A family affair: Job loss and the mental health of spouses and adolescents*. Melbourne Institute Working Paper No. 23/14. Melbourne: University of Melbourne.
- Bunch, S. G., Eastman, B. J., & Moore, R. R. (2007). A profile of grandparents raising grandchildren as a result of parental military deployment. *Journal of Human Behavior in the Social Environment*, 15(4), 1–12.
- Burrell, L. M., Adams, G. A., Briley Durand, D., & Castro, D. C. (2006). The impact of military lifestyle demands on well-being, army and family outcomes. *Armed Forces and Society*, 33(1), 43–58.
- Byrne, T., Montgomery, A. E., & Dichter, M. E. (2013). Homelessness among female veterans: A systematic review of the literature. *Women and Health*, 53(6), 572–596.
- Calhoun, P. S., Beckham, J. C., & Bosworth, H. B. (2002). Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*, 15(3), 205–212.
- Campbell, J. C. (2002). Health consequences of intimate partner violence. *The Lancet*, 359, 1331–1336.

- Caselli, L., & Motta, R. (1995). The effect of PTSD and combat level on Vietnam veterans' perceptions of child behavior and marital adjustment. *Journal of Clinical Psychology, 51*(1), 4–12.
- Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Burns, R. M., Ruder, T., & Han, B. (2010). Children on the homefront: The experience of children from military families. *Pediatrics, 125*, 16–25.
- Chandra, A., Lara-Cinisomo, S., Jaycox, L. H., Tanielian, T., Han, B., Burns, R. M., & Ruder, T. (2011). Views from the homefront: The experiences of youth and spouses from military families. *RAND Health Quarterly, 1*(1), 12.
- Chartrand, M. M., Frank, D. A., White, L. F., & Shope, T. R. (2008). Effect of parents' wartime deployment on the behavior of young children in military families. *Archives of Pediatrics and Adolescent Medicine, 162*(11), 1009–1114.
- Chudal, R., Joelsson, P., Gyllenberg, D., Lehti, V., Leivonen, S., Hinkka-Yli-Salomäki, S., ... Sourander, A. (2015). Parental age and the risk of attention-deficit/hyperactivity disorder: A nationwide, population-based cohort study. *Journal of the American Academy of Child and Adolescent Psychiatry, 54*(6), 487–494.
- Clever, M., & Segal, D. (2013). The demographics of military children and families. *The Future of Children, 23*(2), 13–39.
- Commonwealth of Australia. (2016). *Mental health of Australian Defence Force members and veterans*. Canberra: Department of the Senate, Senate Printing Unit.
- Cozza, S. J., Lerner, R. M., & Haskins, R. (2014). Military and veteran families and children: Policies and programs for health maintenance and positive development. *Social Policy Report, 28*(3), 3–17.
- Crow, J. R., Myers, D. R., Ellor, J. W., Dolan, S. L., & Morissette, S. (2016). Military deployment of an adult child: Ambiguous loss and boundary ambiguity reflected in the experiences of parents of service members. *Marriage and Family Review, 52*(5), 481–509.
- Daigle, P. (2013). *On the homefront: Assessing the well-being of Canada's military families in the new millennium*. [Special Report to the Minister of National Defence]. Ottawa: National Defence and Canadian Forces Ombudsman.
- Danish, S. J., & Antonides, B. J. (2013). The challenges of reintegration for service members and their families. *American Journal of Orthopsychiatry, 83*(4), 550–558.

- Davy, C., Dobson, A., Lawrence-Wood, E., Lorimer, M., Moores, K., Lawrence, A., ... McFarlane, A. (2012). *The Middle East Area of Operations (MEAO) Health Study: Prospective study: Census study report*. Brisbane: Centre for Australian Military and Veterans' Health, University of Queensland.
- Defence Manpower Data Center. (2009). *2008 survey of active duty spouses: Tabulation of responses* [DMDC Report No. 2008-041]. Arlington, VA: DMDC.
- Demers, A. (2009). The war at home: Consequences of loving a veteran of the Iraq and Afghanistan wars. *Internet Journal of Mental Health*, 6(1), 1–25.
- Department of Defence. (2015). *Defence census 2015 fact sheet 5* (April 2015). Canberra: Department of Defence.
- DiMauro, J., Renshaw, K. D., Smith, B. N., & Vogt, D. (2016). Perceived support from multiple sources: Associations with PTSD symptoms. *Journal of Traumatic Stress*, 29(4), 332–339.
- Dirkzwager, A. J., Bramsen, I., Ader, H., & Van Der Ploeg, H. M. (2005). Secondary traumatization in partners and parents of Dutch peacekeeping soldiers. *Journal of Family Psychology*, 19, 217–226.
- Dowling, M. (2014). *Young children's personal, social and emotional development* (4th ed.). London: Sage.
- Dowling, N. A., Youssef, G., Jackson, A. C., Pennay, D., Francis, K. L., Pennay, A., & Lubman, D. I. (2016). National estimates of Australian gambling prevalence: Findings from a dual-frame omnibus survey. *Addiction*, 111(3), 420–435.
- Drummet, A. R., Coleman, M., & Cable, S. (2003). Military families under stress: Implications for family life education. *Family Relations*, 52(3), 279–287.
- Dursun, S., & Sudom, K. (2009). *Impacts of military life on families: Results from the Perstempo Survey of Canadian Forces spouses*. Ottawa: Defence R&D Canada.
- Elbogen, E. B., Fuller, S., Johnson, S. C., Brooks, S., Kinneer, P., Calhoun, P. S., & Beckham, J. C. (2010a). Improving risk assessment of violence among military veterans: An evidence-based approach for clinical decision-making. *Clinical Psychology Review*, 30(6), 595–607.
- Elbogen, E. B., Johnson, S. C., Newton, V. M., Timko, C., Vasterling, J. J., Van Male, L. M., ... & Beckham, J. C. (2014). Protective mechanisms and prevention of violence and aggression in veterans. *Psychological Services*, 11(2), 220–228.
- Elbogen, E. B., Johnson, S. C., Wagner, H. R., Newton, V. M., & Beckham, J. C. (2012). Financial wellbeing and post-deployment adjustment among Iraq and Afghanistan war veterans. *Military Medicine*, 177(6), 669–675.

- Elbogen, E. B., Wagner, H. R., Fuller, S. R., Calhoun, P. S., Kinneer, P. M., & Beckham, J. C. (2010b). Correlates of anger and hostility in Iraq and Afghanistan war veterans. *American Journal of Psychiatry*, 167(9), 1051–1058.
- Elbogen, E. B., Wagner, H. R., Johnson, S. C., Kinneer, P., Kang, H., Vasterling, J. J., ... & Beckham, J. C. (2013). Are Iraqi and Afghanistan veterans using mental health services? New data from a national random-sample survey. *Psychiatric Services*, 64(2), 134–141.
- Ender, M. G. (2006). Voices from the backseat: Demands of growing up in military families. In C. A. Castro, A. B. Adler, & T. W. Britt (Eds.), *Military life: The psychology of serving in peace and combat: Vol. 3: The military family* (pp. 138–166). Westport, CT: Praeger Security International.
- Evans, L., McHugh, T., Hopwood, M., & Watt, C. (2003). Chronic posttraumatic stress disorder and family functioning of Vietnam veterans and their partners. *Australian and New Zealand Journal of Psychiatry*, 37(6), 765–772.
- Fikretoglu, D., Blais, A., & Lam, Q. (2014). Development and validation of a new Theory of Planned Behavior Questionnaire for mental health service use. [Manuscript under revision].
- Fleming, J. (1996). The epidemiology of alcohol use in Australian women: Findings from a national survey of women's drinking. *Addiction*, 91(9), 1325–1334.
- Foran, H. M., Heyman, R. E., & Smith Slep, A. M. (2014). Emotional abuse and its unique ecological correlates among military personnel and spouses. *Psychology of Violence*, 4(2), 128–142.
- Forbes, D., Hawthorne, G., Elliott, P., McHugh, T., Biddle, D., Creamer, M., & Novaco, R. W. (2004). A concise measure of anger in combat-related posttraumatic stress disorder. *Journal of Traumatic Stress*, 17(3), 249–256.
- Forrest, W., Edwards, B., & Daraganova, G. (2014). *Vietnam Veterans Health Study. Vol. 2: A study of health and social issues in Vietnam veteran sons and daughters*. Melbourne: Australian Institute of Family Studies.
- Fox, R. A., Platz, D. L., & Bentley, K. S. (1995). Maternal factors related to parenting practices, developmental expectations, and perceptions of child behavior problems. *Journal of Genetic Psychology*, 156(4), 431–441.
- Gabb, J., Klett-Davies, M., Fink, J., & Thomae, M. (2013). *Enduring love? Couple relationships in the 21st century: Survey findings report*. Milton Keynes: The Open University [online]. Retrieved from <https://www.open.ac.uk/researchprojects/enduringlove/sites/www.open.ac.uk/researchprojects.enduringlove/files/files/ecms/web-content/Final-Enduring-Love-Survey-Report.pdf>.

- Gainsbury, S. M., Russell, A., Hing, N., Wood, R., Lubman, D., & Blaszczynski, A. (2015). How the internet is changing gambling: Findings from an Australian prevalence survey. *Journal of Gambling Studies*, 31(1), 1–15.
- Galovski, T., & Lyons, J. A. (2004). Posttraumatic stress disorder among military returnees from Afghanistan and Iran. *American Journal of Psychiatry*, 163, 586–593.
- Gawande, A. (2004). Casualties of war: Military care for the wounded from Iraq and Afghanistan. *New England Journal of Medicine*, 351, 2471–2475.
- Gershoff, E. T. (2002). Corporal punishment by parents and associated child behaviors and experiences: A meta-analytic and theoretical review. *Psychological Bulletin*, 128(4), 539.
- Gewirtz, A. H., Pinna, K. L. M., Hanson, S. K., & Brockberg, D. (2014). Promoting parenting to support reintegrating military families: After deployment, adaptive parenting tools. *Psychological Services*, 11(1), 31–40.
- Gewirtz, A. H., Polusny, M. A., DeGarmo, D. S., Khaylis, A., & Erbes, C. R. (2010). Posttraumatic stress symptoms among National Guard soldiers deployed to Iraq: Associations with parenting behaviors and couple adjustment. *Journal of Consulting and Clinical Psychology*, 78, 599–610.
- Gibbs, D. A., Clinton-Sherrod, A., & Johnson, R. E. (2012). Interpersonal conflict and referrals to counseling among married soldiers following return from deployment. *Military Medicine*, 177(10), 1178–1183.
- Gibbs, D. A., Martin, S. L., Kupper, L. L., & Johnson, R. E. (2007). Child maltreatment in enlisted soldiers' families during combat-related deployments. *Journal of the American Medical Association*, 298(5), 528–535.
- Gibson, J. L., Griepentrog, B. K., & Marsh, S. M. (2007). Parental influence on youth propensity to join the military. *Journal of Vocational Behavior*, 70(3), 525–541.
- Goff, B. S., Crow, J. R., Reisbig, A. M., & Hamilton, S. (2007). The impact of individual trauma symptoms of deployed soldiers on relationship satisfaction. *Journal of Family Psychology*, 21(3), 344–353.
- Golding, J. M. (1999). Intimate partner violence as a risk factor for mental disorders: A meta-analysis. *Journal of Family Violence*, 14(2), 99–132.
- Goodman, R. (1995). *Strengths and Difficulties Questionnaire* [PDF]. Retrieved from [http://www.sdqinfo.com/py/sdqinfo/b3.py?language=Englishqz\(Austral\)](http://www.sdqinfo.com/py/sdqinfo/b3.py?language=Englishqz(Austral)).

- Gorman, L., Blow, A., Kees, M., Valenstein, M., Jarman, C., & Spira, J. (2014). The effects of wounds of war on family functioning in a National Guard sample: An exploratory study. In S. MacDermid & D. S. Riggs (Eds.), *Military deployment and its consequences for families* (pp. 241–257). New York: Springer.
- Gottman, J. M., Gottman, J. S., & Atkins, C. L. (2011). The Comprehensive Soldier Fitness Program: Family skills component. *American Psychologist*, 66(1), 52–57.
- Gray, M., & Sanson, A. (2005). Growing up in Australia: The Longitudinal Study of Australian Children. *Family Matters*, 72, 4–9.
- Hachey, K. K., Sudom, K., Sweet, J., MacLean, M. B., & Van Til, L. D. (2016). Transitioning from military to civilian life: The role of mastery and social support. *Journal of Military, Veteran and Family Health*, 2(1), 9–17.
- Haro, J. M., Arbabzadeh-Bouchez, S., Brugha, T. S., De Girolamo, G., Guyer, M. E., Jin, R., ... Vilagut, G. (2006). Concordance of the Composite International Diagnostic Interview Version 3.0 (CIDI 3.0) with standardized clinical assessments in the WHO World Mental Health Surveys. *International Journal of Methods in Psychiatric Research*, 15(4), 167–180.
- Harrell, M. C., Lim, N., Castaneda, L. W., & Golinelli, D. (2004). *Working around the military: Challenges of military spouse employment and education*. [Report prepared by the RAND National Defense Research Institute for the Office of the Secretary of Defense]. Santa Monica, CA: RAND Corporation.
- Hendrick, S. S. (1988). A generic measure of relationship satisfaction. *Journal of Marriage and the Family*, 50, 93–98.
- Heyman, R. E., & Neidig, P. H. (1999). A comparison of spousal aggression prevalence rates in U.S. Army and civilian representative samples. *Journal of Consulting and Clinical Psychology*, 67(2), 239–242.
- Hisle-Gorman, E., Nylund, C. M., Tercyak, K. P., Anthony, B. J., & Gorman, G. H. (2015). Impact of parents' wartime military deployment and injury on children's safety and mental health. *Journal of the American Academy of Child and Adolescent Psychiatry*, 54(4), 294–301.
- Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295(9), 1023–1032.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cutting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351(13–22.).

- Holmes, A. K., Rauch, P. K., & Cozza, S. J. (2013). When a parent is injured or killed in combat. *The Future of Children*, 23(2), 143–162.
- Hooper, R., Rona, R. J., Jones, M., Fear, N. T., Hull, L., & Wessely, S. (2008). Cigarette and alcohol use in the UK Armed Forces, and their association with combat exposures: A prospective study. *Addictive Behaviors*, 33(8), 1067–1071.
- Hosek, J., & Wadsworth, S. M. (2013). Economic conditions of military families. *The Future of Children*, 23(2), 41–59.
- Hoskyn, M. J., Iarocci, G., & Young, A. R. (2017). *Executive functions in children's everyday lives: A handbook for professionals in applied psychology*. New York: Oxford University Press.
- Huffman, A. H., & Payne, S. C. (2006). The challenges and benefits of dual-military marriages. In C. A. Castro, A. B. Adler, & T. W. Britt (Eds.), *Military life: The psychology of serving in peace and combat: Vol. 3: The military family* (pp. 115–137). Westport, CT: Praeger Security International.
- Hyatt, K. S., Davis, L. L., & Barroso, J. (2015). Finding the new normal: Accepting change after combat-related mild traumatic brain injury. *Journal of Nursing Scholarship*, 47(4), 300–309.
- Jordan, B. K., Marmar, C. R., Fairbank, J. A., Schlenger, W. E., Kulka, R. A., Hough, R. L., & Weiss, D. S. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, 60(6), 916–926.
- Kalil, A., Haskins, R., & Chesters, J. (2012). *Investing in children: Work, education and social policy in two rich countries*. Washington, DC: Brookings Institute.
- Karney, B. R., & Bradbury, T. N. (1995). The longitudinal course of marital quality and stability: A review of theory, methods, and research. *Psychological Bulletin*, 118(1), 3.
- Karney, B. R., Loughran, D. S., & Pollard, M. S. (2012). Comparing marital status and divorce status in civilian and military populations. *Journal of Family Issues*, 33(12), 1572–1594.
- Keeling, M., Wessely, S., Dandeker, C., Jones, N., & Fear, N. T. (2015). Relationship difficulties among U.K. military personnel: Impact of sociodemographic, military, and deployment-related factors. *Marriage and Family Review*, 51(3), 275–303.
- Kessler, R. C., Andrews, G., Colpe, L. J., Hiripi, E., Mroczek, D. K., Normand, S., ... Zaslavsky, A. M. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32(6), 959–976.

- Knobloch, L. K., Pusateri, K. B., Ebata, A. T., & McGlaughlin, P. C. (2014). Communicative experiences of military youth during a parent's return home from deployment. *Journal of Family Communication, 14*(4), 291–309.
- Knobloch, L. K., & Theiss, J. A. (2012). Experiences of U.S. military couples during the post-deployment transition: Applying the relational turbulence model. *Journal of Social and Personal Relationships, 29*(4), 423–450.
- Knobloch-Fedders, L. M., Caska-Wallace, C., Smith, T. W., & Renshaw, K. (2017). Battling on the home front: Posttraumatic stress disorder and conflict behavior among military couples. *Behavior Therapy, 48*(2), 247–261.
- Kourgiantakis, T., Saint-Jacques, M. C., & Tremblay, J. (2013). Problem gambling and families: A systematic review. *Journal of Social Work Practice in the Addictions, 13*(4), 353–372.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine, 16*(9), 606–613.
- Laffaye, C., Cavella, S., Drescher, K., & Rosen, C. (2008). Relationships among PTSD symptoms, social support, and support source in veterans with chronic PTSD. *Journal of Traumatic Stress, 24*(4), 394–401.
- Laslett, A. M., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S., & Room, R. (2015). *The hidden harm: Alcohol's impact on children and families*. Canberra: Foundation for Alcohol Research and Education.
- Lawson, D. W., & Mace, R. (2009). Trade-offs in modern parenting: A longitudinal study of sibling competition for parental care. *Evolution and Human Behavior, 30*(3), 170–183.
- Lester, P., Peterson, K., Reeves, J., Knauss, I., Glover, D., Mogil, C., ... Beardslee, W. (2010). The long war and parental combat deployment: Effects on military children and at-home spouses. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*(4), 417–432.
- Lester, P. E. (2012). War and military children and families: Translating prevention science into practice. *Journal of the American Academy of Child and Adolescent Psychiatry, 51*(1), 3–5.
- Liang, K.-Y., & Zeger, S. L. (1986). Longitudinal data analysis using generalized linear models. *Biometrika, 73*(1), 13–22.

- Lipari, R. N., Forsyth, B., Bose, J., Kroutil, L. A., & Lane, M. E. (November 2016). *Spouses and children of U.S. military personnel: Substance use and mental health profile from the 2015 National Survey on Drug Use and Health*. In *NSDUH Data Review* (November 2016). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- López Turley, R. N. (2003). Are children of young mothers disadvantaged because of their mother's age or family background? *Child Development*, 74(2), 465–474.
- Loughran, D. (2014). *Why is veteran unemployment so high?* [Report prepared by the RAND National Defense Research Institute for the Office of the Secretary of Defense]. Santa Monica, CA: RAND Corporation.
- Loughran, D. S., & Klerman, J. A. (2008). *Explaining the increase in unemployment compensation for ex-servicemembers during the global war on terror*. RAND National Security Research Division for the Office of the Secretary of Defense – Reserve Affairs. Santa Monica, CA: RAND Corporation.
- Louie, A. D., & Cromer, L. D. (2014). Parent–child attachment during the deployment cycle: Impact on reintegration parenting stress. *Professional Psychology: Research and Practice*, 45(6), 496–503.
- Loxley, W., Toumbourou, J. W., Stockwell, T., Haines, B., Scott, K., Godfrey, C., ... Williams, J. (2004). *The prevention of substance use, risk and harm in Australia: A review of the evidence*. Canberra: Commonwealth of Australia.
- Lu, L., & Rickard, K. (2014). *Value added models for NSW government schools*. A technical paper for the Centre for Education Statistics and Evaluation. Sydney: NSW Department of Education and Communities.
- Lucas, N., Nicholson, J. M., & Maguire, B. (2011). Parenting practices and behaviours. In *The Longitudinal Study of Australian Children annual statistical report 2010* (pp. 43–56). Melbourne: Australian Institute of Family Studies.
- MacDonell, G. V., Bhullar, N., & Thorsteinsson, E. B. (2016). Depression, anxiety, and stress in partners of Australian combat veterans and military personnel: A comparison with Australian population norms. *PeerJ*, 4, e2373.
- MacLean, A. (2010). The things they carry: Combat, disability, and unemployment among U.S. military men. *American Sociological Review*, 75(4), 563–585.
- MacLean, M. B., Van Til, L., Thompson, J. M., Sweet, J., Poirier, A., Sudom, K., & Pedlar, D. J. (2014). Postmilitary adjustment to civilian life: Potential risks and protective factors. *Physical Therapy*, 94(8), 1186–1195.
- Mansfield, A. J., & Engel, C. C. (2011). Understanding substance use in military spouses. *Journal of Clinical Psychology in Medical Settings*, 18(2), 198–199.

- Mansfield, A. J., Kaufman, J. S., Marshall, S. W., Gaynes, B. N., Morrissey, J. P., & Engel, C. C. (2010). Deployment and the use of mental health services among U.S. Army wives. *New England Journal of Medicine*, 362(2), 101–109.
- Marks, G. N. (2006). Family size, family type and student achievement: Cross-national differences and the role of socioeconomic and school factors. *Journal of Comparative Family Studies*, 37(1), 1–24.
- McCarroll, J. E., Fan, Z., Newby, J. H., & Ursano, R. J. (2008). Trends in US Army maltreatment reports 1999–2004. *Child Abuse Review*, 17(2), 108–118.
- McCarroll, J. E., Ursano, R. J., Liu, X., Thayer, L. E., Newby, J. H., Norwood, A. E., & Fullerton, C. S. (2010). Deployment and the probability of spousal aggression by U.S. Army soldiers. *Military Medicine*, 165(1), 41–44.
- McCarroll, J. E., Ursano, R. J., Newby, J. H., Liu, X., Fullerton, C. S., Norwood, A. E., & Osuch, E. A. (2003). Domestic violence and deployment in US Army soldiers. *Journal of Nervous and Mental Disease*, 191(1), 3–9.
- McFarlane, A. C., Hodson, S., Van Hooff, M., & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study: Report*. Canberra: Department of Defence.
- McGuire, A., Dobson, A., Mewton, L., Varker, T., Forbes, D., & Wade, D. (2015). Mental health service use: Comparing people who served in the military or received Veterans' Affairs benefits and the general population. *Australian and New Zealand Journal of Public Health*, 39(6), 524–529.
- McGuire, A., Runge, C., Cosgrove, L., Bredhauer, K., Anderson, R., Waller, M., ... Nasveld, P. (2012). *Timor-Leste Family Study: Summary report*. Brisbane: University of Queensland, Centre for Military and Veterans' Health.
- McManus, D., Dean, K., Al Bakir, M., Iversen, A. C., Hull, L., Fahy, T., ... Fear, N. T. (2012). Violent behaviour in UK military personnel returning home after deployment. *Psychological Medicine*, 42(8), 1663–1673.
- McManus, D., Rona, R., Dickson, H., Somaini, G., Fear, N., & Wessely, S. (2014). Aggressive and violent behavior among military personnel deployed to Iraq and Afghanistan: Prevalence and link with deployment and combat exposure. *Epidemiologic Reviews*, 37(1), 196–212.
- Meadows, S. O., Beckett, M. K., Bowling, K., Golinelli, D., Fisher, M. P., Martin, L. T., ... Osilla, K. C. (2015). *Family resilience in the military: Definitions, models, and policies*. Santa Monica, CA: RAND Corporation.
- Meltzer, H., Gatward, R., Goodman, R., & Ford, T. (2000). *The mental health of children and adolescents in Great Britain*. London: The Stationery Office.

- Miller, N. V., Currie, S. R., Hodgins, D. C., & Casey, D. (2013). Validation of the Problem Gambling Severity Index using confirmatory factor analysis and Rasch modelling. *International Journal of Methods in Psychiatric Research*, 22(3), 245–255.
- Morin, R. (2011). *The difficult transition from military to civilian life*. Washington, DC: Pew Research Center.
- Muir, S. (2018). *Family Wellbeing Study: Part 2: Military Family Approaches to Managing Transition to Civilian Life*. Canberra: Department of Defence and Department of Veterans' Affairs.
- Murphey, D. A., Darling-Churchill, K. E., & Chrisler, A. J. (2011). *The well-being of young children in military families: A review and recommendations for further study*. (Publication No. 2011-21, pp. 1–43). Washington, DC: Child Trends.
- National Center for Education Statistics . (2001). *Early childhood longitudinal study of children*. Washington, DC: US Department of Education.
- National Institute on Drug Abuse. (2013). *Substance abuse in the military*. Bethesda, MD: NIDA.
- Negrusa, B., & Negrusa, S. (2014). Home front: Post-deployment mental health and divorces. *Demography*, 51(3), 895–916.
- Orr Shiffer, C., & Maury, R. (2015). *2015 Annual Military Family Lifestyle Survey*. Institute for Veterans and Military Families (Paper 8).
- Orthner, D., & Rose, R. (2006). *Army support programs and civilian spouse adjustment to deployments*. Washington, DC: Army Research Institute for the Behavioral and Social Sciences.
- O'Toole, B. I., Outram, S., Catts, S. V., & Pierse, K. R. (2010). The mental health of partners of Australian Vietnam veterans three decades after the war and its relation to veteran military service, combat, and PTSD. *Journal of Nervous and Mental Disease*, 198(11), 841–845.
- Padden, D. L., Connors, R. A., & Agazio, J. G. (2011). Stress, coping and well-being in military spouses during deployment separation. *Western Journal of Nursing Research*, 33(2), 247–267.
- Paris, R., Devoe, E. R., Ross, A. M., & Acker, M. L. (2010). When a parent goes to war: Effect of parental deployment on very young children and implications for intervention. *American Journal of Orthopsychiatry*, 80(4), 610–618.
- Park, N. (2011). Military children and families. *American Psychologist*, 66(1), 65–72.

- Pietrzak, E., Pullman, S., Cotea, C., & Nasveld, P. (2013). Effects of deployment on health behaviours in military forces: A review of longitudinal studies. *Journal of Military and Veterans' Health*, 21(1), 14–23.
- Pinder, R. J., Iversen, A. C., Kapur, N., Wessely, S., & Fear, N. (2011). Self-harm and attempted suicide among UK Armed Forces personnel: Results of a cross-sectional survey. *International Journal of Social Psychiatry*, 58(4), 433–439.
- Pittman, J. F., Kerpelman, J. L., & McFadyen, J. M. (2004). Internal and external adaptation in army families: Lessons from Operations Desert Shield and Desert Storm. *Family Relations: Interdisciplinary Journal of Applied Family Studies*, 53(3), 249–260.
- Posada, G., Longoria, N., Cocker, C., & Lu, T. (2011). Attachment ties in military families: Mothers' perception of interactions with their children, stress, and social competence. In S. M. Wadsworth & D. Riggs (Eds.), *Risk and resilience in US military families* (pp. 131–147). New York: Springer.
- Possemato, K., Pratt, A., Barrie, K., & Ouimette, P. (2015). Family functioning in recent combat veterans with posttraumatic stress disorder and alcohol misuse. *Traumatology*, 21(4), 267–272.
- Qu, L., Soriano, G., & Weston, R. (2006). Starting early, starting late: The health and wellbeing of mother and child. *Family Matters*, (74), 4–11.
- Rabenhorst, M. M., McCarthy, R. J., Thomsen, C. J., Milner, J. S., Travis, W. J., Foster, R. E., & Copeland, C. W. (2013). Spouse abuse among United States Air Force personnel who deployed in support of Operation Iraqi Freedom/Operation Enduring Freedom. *Journal of Family Psychology*, 27(5), 754–761.
- Ray, S. L., & Heaslip, K. (2011). Canadian military transitioning to civilian life: A discussion paper. *Journal of Psychiatric and Mental Health Nursing*, 18, 198–204.
- Reed, S. C., Bell, J. F., & Edwards, T. C. (2011). Adolescent well-being in Washington state military families. *American Journal of Public Health*, 101(9), 1676–1682.
- Rentz, E. D., Marshall, S. W., Loomis, D., Casteel, C., Martin, S. L., & Gibbs, D. A. (2007). Effect of deployment on the occurrence of child maltreatment in military and nonmilitary families. *American Journal of Epidemiology*, 165(10), 1199–1206.
- Repetti, R. L., Matthews, K. A., & Waldron, I. (1989). Employment and women's health: Effects of paid employment on women's mental and physical health. *American Psychologist*, 44(11), 1394.
- Rickwood, D., Magor-Blatch, L., Mattick, R., Gruenert, S., Zavrou, N., & Akers, A. (2008). *Substance use: A position statement prepared for the Australian Psychological Society*. Melbourne: Australian Psychological Society.

- Riggs, S. A., & Riggs, D. S. (2011). Risk and resilience in military families experiencing deployment: The role of the family attachment network. *Journal of Family Psychology*, 25(5), 675–687.
- Riviere, L., Kendall-Robbins, A., McGurk, D., Castro, C. A., & Hoge, C. W. (2011). Coming home may hurt: Risk factors for mental ill health in US reservists after deployment in Iraq. *British Journal of Psychiatry*, 198(2), 136–142.
- Robinson, E., Rodgers, B., & Butterworth, P. (2008). Family relationships and mental illness. *AFRC Issues*, 1–19.
- Rosen, L. N., Moghadam, L. Z., & Vaitkus, M. A. (1989). The military family's influence on soldiers' personal morale: A path analytic model. *Military Psychology*, 1(4), 201–213.
- Ross, A. M., & DeVoe, E. R. (2014). Engaging military parents in a home-based reintegration program: A consideration of strategies. *Health and Social Work*, 39(1), 47–54.
- Roy Morgan. (2016). Job security is great for principals, police, priests and (some) CEOs – but journalists, taxi drivers, scientists and (other) CEOs feel most unstable. [Press release, 20 April 2016].
- Runge, C. E., Waller, M., MacKenzie, A., & McGuire, A. C. (2014). Spouses of military members' experiences and insights: Qualitative analysis of responses to an open-ended question in a survey of health and wellbeing. *PLOS One*, 9(12), e114755.
- Ruscio, A. M., Weathers, F. W., King, L. A., & King, D. W. (2002). Male war-zone veterans' perceived relationships with their children: The importance of emotional numbing. *Journal of Traumatic Stress*, 15(5), 351–357.
- Saunders, J. B., Aasland, O. G., Babor, T. F., de la Fuente, J. R., & Grant, M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption-II. *Addiction*, 88(6), 791–804.
- Savarese, V. W., Suvak, M. K., King, L. A., & King, D. W. (2001). Relationships among alcohol use, hyperarousal, and marital abuse and violence in Vietnam veterans. *Journal of Traumatic Stress*, 14(4), 17–32.
- Sayer, N. A., Frazier, P., Orazem, R. J., Murdoch, M., Gravely, A., Carlson, K. F., ... Noorbaloochi, S. (2011). Military to civilian questionnaire: A measure of postdeployment community reintegration difficulty among veterans using Department of Veterans Affairs medical care. *Journal of Traumatic Stress*, 24(6), 660–670.

- Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70(2), 163–170.
- Sharp, M. L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews*, 37, 144–162.
- Sharpley, C. F., & Rogers, H. J. (1984). Preliminary validation of the Abbreviated Spanier Dyadic Adjustment Scale: Some psychometric data regarding a screening test of marital adjustment. *Educational and Psychological Measurement*, 44(4), 1045–1049.
- Sheppard, S. C., Malatras, J. W., & Israel, A. C. (2010). The impact of deployment on U.S. military families. *American Psychologist*, 65(6), 599–609.
- Sherman, M. D., Larsen, J., & Borden, L. M. (2015). Broadening the focus in supporting reintegrating Iraq and Afghanistan veterans: Six key domains of functioning. *Professional Psychology: Research and Practice*, 46(5), 355–365.
- Shipherd, J. C., Stafford, J., & Tanner, L. R. (2005). Predicting alcohol and drug abuse in Persian Gulf War veterans: What role do PTSD symptoms play? *Addictive Behaviors*, 30(3), 595–599.
- Shirt, L. (2012). *2011 Australian Defence Force Exit Survey preliminary report*. Canberra: Directorate of Strategic Personnel Policy Research, Department of Defence.
- Sim, M. R., Clarke, D., Forbes, A. B., Glass, D., Gwini, S., Ikin, J. F., ... McNell, J. (2015). *Australian Gulf War follow-up health study: Technical report*. Canberra: Department of Veterans' Affairs.
- Sinha, R. (2008). Chronic stress, drug use, and vulnerability to addiction. *Annals of the New York Academy of Sciences*, 1141(1), 105–130.
- Skinner, N., Hutchinson, C., & Pocock, B. (2012). *The big squeeze: Work, home and care in 2012*. Adelaide: Centre for Work and Life, University of South Australia.
- Skomorovsky, A. (2014). Deployment stress and well-being among military spouses: The role of social support. *Military Psychology*, 26, 44–54.
- Slade, T., Johnston, A., Teesson, M., Whiteford, H., Burgess, P., Pirkis, J., & Saw, S. (2009). *The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*. Canberra: Department of Health and Ageing.
- Smith-Marek, E. N., Cafferky, B., Dominguez, M. M., Spencer, C., Van, K., Stith, S. M., & Oliver, M. A. (2016). Military/civilian risk markers for physical intimate partner violence: A meta-analysis. *Violence and Victims*, 31(5), 787–818.

- Solomon, Z., Dekel, R., & Mikulincer, M. (2008). Complex trauma of war captivity: A prospective study of attachment and post-traumatic stress disorder. *Psychological Medicine*, 38(10), 1427–1434.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092–1097.
- Sripada, R. K., Lamp, K. E., Defever, M., Venners, M., & Rauch, S. A. (2016). Perceived social support in multi-era veterans with posttraumatic stress disorder. *Journal of Nervous and Mental Disease*, 204(4), 317–320.
- Stander, V. A., & Merrill, L. L. (2000). *The relationship between parental military background to the demographic characteristics of 11,195 Navy recruits*. [Report No. 00-14]. San Diego, CA: Naval Health Research Center.
- StataCorp. (2017). Stata Statistical Software: Release 15. College Station, TX: StataCorp LLC.
- Statistics Canada. (2000). *National Longitudinal Study of Children and Youth*. [Cycle 4]. Ottawa, ON: Statistics Canada.
- Stats NZ. (2017). *Potentially hazardous drinking*. [New Zealand Health Survey]. Wellington: Ministry of Health.
- Stormshak, E. A., Bierman, K. L., McMahon, R. J., & Lengua, L. J. (2000). Parenting practices and child disruptive behavior problems in early elementary school. *Journal of Clinical Child Psychology*, 29(1), 17–29.
- Suchman, N. E., & Luthar, S. S. (2000). Maternal addiction, child maladjustment and socio-demographic risks: Implications for parenting behaviors. *Addiction*, 95(9), 1417–1428.
- Sullivan, K., Barr, N., Kintzle, S., Gilreath, T., & Castro, C. A. (2016). PTSD and physical health symptoms among veterans: Association with child and relationship functioning. *Marriage and Family Review*, 52(7), 689–705.
- Sullivan, K. T., & Lawrence, E. (Eds.). (2016). *The Oxford handbook of relationship science and couple interventions*. New York: Oxford University Press.
- Tanielian, T., & Jaycox, L. H. (Eds.) (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation.
- Tansey, C. M., Raina, P., & Wolfson, C. (2013). Veterans' physical health. *Epidemiologic Reviews*, 35, 66–74.

- Thomas, J. L., Wilk, J. E., Riviere, L. A., McGurk, D., Castro, C. A., & Hoge, C. W. (2010). Prevalence of mental health problems and functional impairment among Active Component and National Guard soldiers 3 and 12 months following combat in Iraq. *Archives of General Psychiatry*, 67(6), 614–623.
- Trautman, J., Alhusen, J., & Gross, D. (2015). Impact of deployment on military families with young children: A review. *Nursing Outlook*, 63, 656–679.
- Trewick, N., & Muller, J. (2014). Unemployment in military spouses: An examination of the latent and manifest benefits, quality of life, and psychological wellbeing. *Australian Journal of Career Development*, 23(2), 47–56.
- Tsai, J., Link, B., Rosenheck, R. A., & Pietrzak, R. H. (2016). Homelessness among a nationally representative sample of US veterans: Prevalence, service utilization, and correlates. *Social Psychiatry and Psychiatric Epidemiology*, 51(6), 907–916.
- Tsai, J., & Rosenheck, R. A. (2015). Risk factors for homelessness among US veterans. *Epidemiologic Reviews*, 37, 177–195.
- Twenge, J. M., Campbell, W. K., & Foster, C. A. (2003). Parenthood and marital satisfaction: A meta-analytic review. *Journal of Marriage and Family*, 65(3), 574–583.
- Van Hooff, M., Lawrence-Wood, E., Hodson, S., Sadler, N., Benassi, H., Hansen, C., ... McFarlane, A. (2018). *Mental health prevalence: Mental Health and Wellbeing Transition Study*. Canberra: Department of Defence and Department of Veterans' Affairs.
- VanDeMark, N. R., Russell, L. A., O'Keefe, M., Finkelstein, N., Noether, C. D., & Gampel, J. C. (2005). Children of mothers with histories of substance abuse, mental illness, and trauma. *Journal of Community Psychology*, 33(4), 445–459.
- Vassallo, S., & Sanson, A. (Eds.). (2013). *The Australian Temperament Project: The first 30 years*. Melbourne: Australian Institute of Family Studies.
- Vogt, D. (2011). Mental health-related beliefs as a barrier to service use for military personnel and veterans: A review. *Psychiatric Services*, 62(2), 135–142.
- Vogt, D., Smith, B. N., Fox, A. B., Amoroso, T., Taverna, E., & Schnurr, P. P. (2016). Consequences of PTSD for the work and family quality of life of female and male U.S. Afghanistan and Iraq war veterans. *Social Psychiatry and Psychiatric Epidemiology*, 52, 341–352.
- Volberg, R. A., & Williams, R. J. (2012). *Developing a short form of the PGSI*. [Report to the Gambling Commission, January 2012].

- Wagner, M. E., Schubert, H. J., & Schubert, D. S. (1985). Effects of sibling spacing on intelligence, interfamilial relations, psychosocial characteristics, and mental and physical health. In *Advances in child development and behavior* (Vol. 19, pp. 149–206). Orlando, FL: Elsevier.
- Walsh, T. B., Dayton, C. J., Erwin, M. S., Muzik, M., Busuito, A., & Rosenblum, K. L. (2014). Fathering after military deployment: Parenting challenges and goals of fathers of young children. *Health and Social Work, 39*(1), 35–44.
- Ware Jr, J. E., & Sherbourne, C. D. (1992). The MOS 36-item short-form health survey (SF-36): I. Conceptual framework and item selection. *Medical Care, 30*(6), 473–483.
- Warr, P., & Parry, G. (1982). Paid employment and women's psychological well-being. *Psychological Bulletin, 91*(3), 498–516.
- Washington, D. L., Yano, E. M., McGuire, J., Hines, V., Lee, M., & Gelberg, L. (2010). Risk factors for homelessness among women veterans. *Journal of Health Care for the Poor and Underserved, 21*(1), 81–91.
- Watson, N., & Wooden, M. (2002). *The Household, Income and Labour Dynamics in Australia (HILDA) Survey: Wave 1 survey methodology*. Melbourne Institute HILDA Technical Paper Series Vol. 1/02. Melbourne: University of Melbourne.
- Weathers, F. W., Litz, B. T., Herman, D. S., Huska, J. A., & Keane, T. M. (1993). *The PTSD Checklist (PCL): Reliability, validity, and diagnostic utility*. [Paper presented at the the 9th Annual Conference of the International Society for Traumatic Stress Studies, San Antonio, TX].
- Wiens, T. W., & Boss, P. (2006). Maintaining family resiliency before, during and after military separation. In C. A. Castro, A. B. Adler, & T. W. Britt (Eds.), *Military life: The psychology of serving in peace and combat: Vol. 3: The military family* (pp. 13–38). Westport, CT: Praeger Security International.
- Wilkins, R. (2015). *The Household, Income and Labour Dynamics in Australia Survey: Selected findings from waves 1 to 12*. Melbourne: Melbourne Institute of Applied Economic and Social Research, University of Melbourne.
- WithYouWithMe. (2017). *Veteran employment report* [online]. Retrieved from <https://create.piktochart.com/output/21845816-veteran-employment-report-final-conflict-copy>.
- Woo, H. (2009). Better to have it all?: Employment, motherhood and women's psychological well-being. [Poster presented at the Annual Meetings of the Population Association of America.] Detroit, MI.

- Woodward, L. J., Fergusson, D. M., Chesney, A., & Horwood, L. J. (2007). Punitive parenting practices of contemporary young parents. *New Zealand Medical Journal* [online], 120, 1267.
- Woodworth, J., Canul, G., & Morrison, E. (2014). *Relationship between Marine Corps wives' stress and perceived social support: Social support plays a critical role in family well-being among military personnel, but is it enough?* Washington, DC: Society for Military Psychology.
- World Health Organization. (2004). *Global status report on alcohol 2004*. Geneva: Department of Mental Health and Substance Abuse, WHO.
- Worthen, M., Moos, R., & Ahern, J. (2012). Iraq and Afghanistan veterans' experiences living with their parents after separation from the military. *Contemporary Family Therapy*, 34(3), 362–375.
- Wright, K. M., Riviere, L. A., Merrill, J. C., & Cabrera, O. A. (2013). Resilience in military families: A review of programs and empirical evidence. In R. R. Sinclair & T. W. Britt (Eds.), *Building psychological resilience in military personnel: Theory and practice*. Washington, DC: American Psychological Association.
- Zubrick, S. R., Lucas, N., Westrupp, E. M., & Nicholson, J. M. (2014). *Parenting measures in the Longitudinal Study of Australian Children: Construct validity and measurement quality, Waves 1 to 4*. LSAC Technical Paper no. 12. Canberra: Department of Social Services.
- Zubrick, S. R., Smith, G. J., Nicholson, J., Sanson, A., & Jackiewicz, T. A. (2008). *Parenting and families in Australia*. FaHCSIA Social Policy Research Paper No. 43. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.

PART 2
**Military Family Approaches to Managing
Transition to Civilian Life**

Key findings

Part 2 contains the results of the qualitative research of the Family Wellbeing Study (FWS). This exploratory qualitative research component was designed to build understanding of how families manage the transition of Australian Defence Force (ADF) members into civilian life. In particular, the study aimed to explore family strategies and approaches for achieving their transition goals or managing post-transition life.

The Department of Veterans' Affairs (DVA) commissioned the Australian Institute of Family Studies to undertake this qualitative research as a complement to the Part 1 quantitative component of the FWS. The FWS is one of three studies that sit within the Transition and Wellbeing Research Programme. The Programme is a joint research initiative of DVA and the Department of Defence.

The qualitative research was based on analysis of data from semi-structured qualitative interviews with 25 adult family members (including partners, parents and children over 18) of ex-serving ADF members. Interviews were undertaken between March and July 2017. Participants in the interviews were drawn from a sampling frame of people who had completed the online survey component of the FWS (for Part 1) and who had a family member who was an ex-serving member of the ADF.

The key findings from this study were as follows:

- Ex-serving members with mental health issues and/or who had been medically discharged from the ADF tended to have relatively challenging transitions and could require significant family support. The effort of supporting the ex-serving member could also put stress on family relationships. Families and ex-serving members could be challenged by the symptoms of the health issue itself, as well as by transition-related issues such as difficulties in finding satisfactory employment or maintaining post-transition social networks.
- Participants did not describe or articulate a single type of 'successful transition'. Rather, participant life circumstances strongly influenced their transition goals and/or assessments of post-transition life. Family assessments of the relative success of transition could also change over time. However, families did emphasise the importance of general quality of life issues, such as financial security or harmonious family relationships, when discussing their transition outcomes. Further focused research on transition outcomes could explore concrete outcomes, such as employment status, as well as formal quality of life measures to

explore member and family changes in life quality before, during and after transition.

- Families are deeply implicated in, and affected by, transition from the military. In particular, families (particularly partners) described their role in transition planning and their assistance with family life and emotional support.
- The practical and emotional support provided by family members varied according to their own capacity and skills and according to the needs of the ex-serving member. In particular, ex-serving members who had serious health issues (which may or may not have been associated with a medical discharge), and/or who had experienced difficulty finding employment, could require high levels of support. Family involvement in transition planning was also variable but was less clearly associated with any single factor.
- Although there was no definitive account of what constituted a ‘successful’ transition, participant accounts indicated that ex-serving members and their families tended to have better outcomes (or were better able to mitigate life challenges) when transition planning began early and when families were involved in the planning process. Open communication between ex-serving members and their families could enhance the planning process, and make for a more harmonious post-transition life. However, ex-serving members with a mental illness (and their families) could also find such communication difficult or challenging.
- Family members identified several key areas of external support that they believed would assist them or the ex-serving member to achieve better transition outcomes. In particular, there was an expressed desire for more individualised transition preparation. The families of ex-serving members with complex needs, particularly those with mental health issues and/or who had been medically discharged, also indicated a particular desire for personalised transition case management or case coordination. Such support for ex-serving members was perceived as potentially having a significant effect on how families coped with transition.
- Participants were often unsure of what support services were available to them or to the ex-serving member. This could make it difficult for them to access services themselves or to encourage the ex-serving member to access appropriate services. The inconsistency of family knowledge about services, and their subsequently inconsistent service use, suggests that improved communication with ex-serving members and their families could be beneficial. However, it is also important to note that participant accounts of transition support reflected their experiences at the time of the ex-serving members’ transition and may not reflect transition initiatives or service changes that have been instituted after their transition.

6 Introduction

6.1 Background to the study

Part 2 contains the results of an exploratory qualitative research study that investigated the transition experiences of families of ex-serving members of the Australian Defence Force (ADF).⁸ The Department of Veterans' Affairs (DVA) commissioned the Australian Institute of Family Studies (AIFS) to undertake this research as a component part of the Family Wellbeing Study (FWS). Ethical clearance was received from the DVA Human Research Ethics Committee.

The FWS is one of three studies that sits within the Transition and Wellbeing Research Programme. The Programme is a joint research initiative of DVA and the Department of Defence (Defence) that aims to examine the effect of contemporary military service on the mental, physical and social health of serving and ex-serving ADF members and their families.

There are currently three studies that contribute to this programme. These are:

- the Mental Health and Wellbeing Transition Study (MHWTS) led by the Centre for Traumatic Stress Studies at the University of Adelaide
- the Impact of Combat Study led by the Centre for Traumatic Stress Studies
- the Family Wellbeing Study (led by AIFS and with two parts).

The FWS was initiated by DVA and Defence in order to increase knowledge about the health and welfare of the family members of current and ex-serving ADF members and to build understanding about the challenges and opportunities faced by military families during and after military service. The FWS comprised two separate but related parts: *Part 1: Families of Current and Ex-Serving ADF Members: Health and Wellbeing*, a quantitative component; and *Part 2: Military Family Approaches to Managing Transition to Civilian Life*, a qualitative component.

- **Part 1: Families of Current and Ex-Serving ADF Members: Health and Wellbeing.** The quantitative component was intended to provide an overview of the composition and experiences of military families during and after military service.

⁸ For the sake of consistency, in this study 'ex-serving members' refers to members who have left all ADF service, as well as to those who have left full-time ADF service but are still currently in the ADF Reserves. 'Transitioning member' refers more generally to ADF members who are in the process of transition.

Participants in Part 1 of the FWS were recruited via a two-stage process whereby current and ex-serving (including reservist) ADF members who had completed the MHWTS survey were asked to nominate a family member (i.e. partner, parent, sibling or child over 18) who could be invited to participate in the FWS. Nominated family members of the MHWTS respondents who had agreed to inform their family members about the FWS, and who had provided their family members' contact details, were invited to complete a 30-minute online survey. Analysis of the survey data aimed to provide information about the diversity of military families, their service use and the impact of military service on their psychosocial health. The findings from the quantitative study are contained in Part 1.

- **Part 2: Military Family Approaches to Managing Transition to Civilian Life.** This exploratory qualitative research focused on a small number of family members who had completed the online FWS survey. Part 2 aimed to investigate family involvement in managing the transition from the ADF and to explore what families can do to achieve better transition outcomes. This part is described in more detail below.

6.2 Family Wellbeing Study: Part 2: Military Family Approaches to Managing Transition to Civilian Life

The qualitative research in Part 2 was prompted, in part, by DVA's recognition that there is relatively little empirical research on how families manage the process of a serving member's transition from the ADF into civilian life. There is some existing research literature addressing the challenges of transition, family resilience and the effects of transitioning members' ill health on family functioning (e.g. see Wiens & Boss, 2006; Bowling & Sherman, 2008; MacDermid, Samper, Schwarz, Nishida, & Nyaronga, 2008; Berle & Steel, 2015). However, there is far less research on how families plan for transition, support transitioning members or try to maximise transition outcomes. This qualitative research project was thus designed as an exploratory study that can begin to address these gaps in understanding and to outline preliminary themes for future research and/or policy design.

The study had two key research goals:

- to explore how families help manage the transition of ADF members into civilian life and how this is achieved in different contexts or circumstances
- to explore family strategies and approaches for achieving better transition outcomes and to collect accounts of transition that could be shared with other families of current or ex-serving ADF members.

Another key aim of the qualitative study was to collect a form of data – quotes and case studies – that can help the families of current and ex-serving members to ‘see themselves’ in DVA research and thus feel more engaged in the research process. Although the study touches on some of the challenges of transition, the study’s key focus was to learn more about what families do to manage the transition process, what they thought had worked best for them and what they would advise other families to do.

In achieving these overarching research goals, four sub-questions guided the study. These were:

- What does a ‘successful’ transition from the ADF look like to member families?
- What factors lead to the successful transition of an ADF member?
- How do family members contribute to the successful transition of an ADF member?
- What strategies or approaches can help current and ex-serving ADF member families improve their transition outcomes?

6.3 Structure of Part 2

The following chapter provides a description of the sampling strategy and research methodology used in Part 2. The research findings are then presented in the three subsequent chapters. Chapter 8 considers some of the transition challenges, life circumstances and structural and environmental factors that shaped participants’ (and ex-serving members’) experiences of transition. It also explores family and member hopes and expectations about life after transition from the ADF. Chapter 9 explores the role of families in supporting members during and after transition from the ADF. Chapter 10 outlines participant strategies and actions for building a satisfactory life during and after transition. Part 2 closes with a discussion of the overall findings and their implications for future research and policy.

7 Study design and research methods

7.1 Sampling and recruitment

Part 2, the qualitative component of the FWS, was based on semi-structured telephone interviews with 25 family members of ex-serving ADF members. Participants in the qualitative interviews were drawn from a larger sampling frame of respondents to the online survey component of the FWS (the Part 1 quantitative component). Participants in the FWS survey had in turn been nominated as family members (and thus eligible for the FWS online survey) by current or ex-serving ADF members who had completed the MHWTS survey.

Inclusion criteria for the sampling frame that was drawn from respondents to the FWS survey were:

- the respondent was over 18
- the respondent had a family member who had transitioned from full-time service in the ADF
- the respondent had agreed to be contacted for future research
- the respondent was the family member of an ex-serving ADF member who had agreed to have their MHWTS survey data linked to their nominated family member's FWS survey data.

The exclusion criteria for this sampling frame were:

- the responding family member was a current serving ADF member at the time of the survey
- the ex-serving ADF member who had nominated the participating family member had any of the following discharge types:
 - compulsory age retirement
 - assessed as unsuitable for further training
 - end of limited tenure appointment
 - not offered re-engagement/re-appointment
 - accepted voluntary redundancy
 - compassionate grounds
 - non-voluntary discharge – administrative.

The above discharge types were excluded from the sampling at DVA's request and/or because the numbers of eligible people in each category were too low to allow them to be anonymised. Although the family of ex-serving ADF members who discharged due to reaching the compulsory retirement age of 60 were excluded from the sample, the family of ex-serving members who self-described their voluntary discharge as 'retirement' (and who discharged before 60) were included.

Following the application of these inclusion and exclusion criteria, the sampling frame of 306 people was drawn for Part 2 of the FWS. AIFS researchers then selected a sample of potential participants for the qualitative interviews from this sampling frame. The sample of participants who were invited to participate was not intended to be statistically representative; rather, the sampling strategy was to explore a range of participant characteristics and transition experiences. In particular, a key goal was to ensure that families who had a relatively high risk of 'challenging' transition experiences were included in the study. The aim of including such families was to explore what strategies, approaches or supports they had found most helpful given their circumstances. Inclusion of families with a high potential for challenging transitions was achieved by oversampling families with an ex-serving member who had been medically discharged and/or who had a score on the Kessler Psychological Distress 10-item scale (K10) – taken from their response to the K10 questionnaire in the MHWTS survey – that indicated high levels of psychological distress.⁹ Medical discharge was included as proxy for a raised risk of challenging transitions because it indicated a potentially greater need for services and/or family caregiving and because it suggested a transition to civilian life that the ex-serving member had not necessarily desired or planned. However, it was not assumed that medical discharge or a high K10 score always indicated a difficult transition or that other ex-serving members did not face transition challenges. Further, it should be noted that some voluntarily discharged ex-serving members also had health issues that could require family care or support from services.

Because the sampling frame was drawn from people who had completed the online FWS survey, and who had previously been nominated as 'family members' by respondents to the MHWTS survey, a specific definition of who counts as 'family' was not developed for this study. Rather, anyone who had participated in the FWS survey (and met the inclusion criteria outlined above) was potentially eligible for this study. However, in choosing participants for interview, the researchers focused on the adult (i.e. over 18 years old) family members most likely to have had significant input into, or been affected by, transition. In most instances, these were the parents or partners of transitioned ADF members.

⁹ The K10 is a widely used screening measure for psychological distress. K10 scores over 22 were used to indicate high or very high levels of psychological distress; this cut-off was derived from the scoring used by the Centre for Traumatic Stress Studies in the other Transition and Wellbeing Research Programme studies.

Using these principles, and following consultation with DVA and Defence stakeholders and the programme's Scientific Advisory Committee, the researchers created selection criteria for choosing people to be invited to participate in an interview. The sampling criteria were as follows:

- Type of discharge: the sample was divided into two groups: 1) the family of medically discharged ADF members; and 2) the family of voluntarily discharged (including voluntarily retired) ADF members. The second category contained three classes of voluntary separation from the ADF: discharge/resignation at own request; end of fixed-period engagement; and end of initial enlistment period/return of service obligation.
- Mental health indicators: the sample included a subsample of participants who were the family of an ex-serving member. Half of the sample of family of medically discharged members, and over 40% of the total sample, had a transitioned member with a K10 score indicating high levels of psychological distress (i.e. a K10 score of over 22).
- Service type: the family of transitioned members of the three ADF service types were represented in the sample. There were at least six interviews for each of the service types.
- Relationship to member: the sample aimed to include both parents and partners of transitioned ADF members.

7.1.1 Recruitment and the study sample

The recruitment process for Part 2 involved a series of steps that allowed for different approaches to contacting potential participants. An initial shortlist of 25 potential participants was selected from the sample frame using the selection criteria above. An invitation letter and information sheet were posted or emailed to the selected participants. Potential participants were subsequently telephoned (and/or emailed) to invite them to participate and to make a time for an interview. When potential participants chose to not take part or could not be contacted (after five contact attempts), another potential participant with matching characteristics was selected from the sampling frame.

The composition of the final achieved sample is outlined in Table 7.1. Twenty of the interviewed family members were female, 18 were partners of a transitioned member and six were parents. One adult child of a transitioned member was interviewed. Family members of all three Services were represented; there were interviews with the family of former members of the Navy (8), Army (11) and Air Force (6).

Table 7.1 Participant characteristics

	Total number	Ex-serving member had K10 score indicating psychological distress	Relationship to ex-serving member: partner	Relationship to ex-serving member: parent	Relationship to ex-serving member: other
Family of medically discharged members	12	6	9	3	0
Family of voluntarily discharged members	13	5	9	3	1
Total	25	11	18	6	1

7.2 Research methods

Data collection for the study consisted of 25 semi-structured qualitative interviews with adult family members of transitioned ADF members. Interviews were undertaken between March and July 2017. The semi-structured, qualitative interviews explored:

- family circumstances
- the reasons for a member's transition and the events and circumstances surrounding separation from the ADF
- member and family hopes and expectations about transition and their post-transition life
- how members and families managed the transition into civilian life
- key challenges in the transition experience
- the strategies or approaches that participating families adopted, and the resources they used, in their attempts to achieve satisfactory post-transition lives
- what additional supports might have helped members and families achieve better transition outcomes
- participant advice to other families contemplating or undergoing transition.

Questions within these broad themes were largely open-ended in order to allow participants to use their own words to narrate their perceptions and experiences of transition and to describe what parts of the transition experience they thought were most important to their family life. Issues raised by participants that were not part of the interview schedule were followed up where they were of relevance to the research questions. All of the interviews were completed over the telephone and were between 20 and 70 minutes long. Interviews were recorded and transcribed. Thematic analysis of the interview transcripts and interviewer notes was subsequently undertaken to

identify key themes or patterns in how different participants experienced transition, what they found most helpful, what had the biggest positive or negative impact on their experience, and what could have improved their experience of transition and post-transition outcomes.

In Part 2, participant case studies and quotes taken from the interviews have been used to illustrate important themes and to provide concrete examples of the ways in which some participants managed the transition process. These case studies are not intended to be representative of all transition experiences. All participant names used in Part 2 are pseudonyms.

8 The context of family involvement: Transition challenges and expectations

This study focused on how families supported transitioning and ex-serving members and how they attempted to achieve transition goals or maintain family functioning. However, family involvement in transition did not take place in a vacuum but rather was influenced by the context in which transition took place. Hence, to provide some context for family attempts to manage the transition process, this chapter summarises the transition challenges described by participants, the circumstances that family members saw as underlying or exacerbating transition challenges (or forms of support), and how life challenges and circumstances shaped expectations about what constituted a ‘successful’ transition.

8.1 Transition challenges

There is a growing body of research evidence that suggests that ex-serving military members can struggle to reintegrate into civilian life and that such struggles can affect their families (e.g. see Berle & Steel, 2015; Bowling & Sherman, 2008). There is, for example, research suggesting that members who have spent a significant time living away from their family can have trouble re-establishing intimacy or adapting to changed family roles and that this can result in family conflict and relationship breakdown; in these circumstances, it is often the families who assume the role of maintaining relationships and helping the ex-serving member to adjust (Dekel, Solomon, & Bleich, 2005; McFarlane, 2009; Lester & Flake, 2013). Ex-serving members can also struggle to find stable or satisfactory employment after transitioning and this can have an effect on their self-esteem and sense of identity (Tanielian & Jaycox, 2008; Verey & Smith, 2012).

Both the risks and the effects of such transition challenges – for members and for families – can be heightened when the transitioning member has serious physical or mental health issues (Galovski & Lyons, 2004; Morin, 2011). For example, in one US study of ‘new veterans’ referred for mental health screening, 75% of those who were assessed as having a mental health disorder reported high rates of family conflict and more than 50% reported events of family violence (Sayers, Farrow, Ross, & Oslin, 2009). Families are also commonly the main source of support and caregiving for ex-serving members and the demands of caring can have a significant negative effect on family functioning and personal relationships (Galovski & Lyons, 2004). Female partners, in particular, can suffer emotional distress and have high feelings of burden

as a result of their caregiving role, while ex-serving members with a serious physical or mental health issue can struggle to adjust to their altered, and sometimes diminished, family role (Dekel et al., 2005; Holmes, Rauch, & Cozza, 2013). Families who have had repeated experience of setbacks, whether before or after the injury or illness, can also have a reduced ability to bounce back from adversity (Holmes et al., 2013).

Consistent with the international literature on transition challenges, the families in this study who had an ex-serving member with poor physical or mental health were the most likely to experience a range of major life challenges related to transition. This was, to some extent, anticipated in the research design and the deliberate oversampling of medically discharged ex-serving members and ex-serving members with an indication of psychological distress. This is not to say that such families necessarily had an 'unsuccessful' transition; the following chapters give some examples of the ways in which families and ex-serving members could manage their challenges and meet life goals. Nor was it the case that the families of ex-serving members without serious health issues did not experience any transition challenges. However, families with an ill or injured ex-serving member tended to face a wider range of challenges. For example, participants described medically discharged ex-serving members as frequently emotionally unprepared or unwilling to leave the ADF, and the member's subsequent transition could be associated with the loss of self-identity described by Tanielian and Jaycox (2008) or with lingering feelings of resentment or anger. Family relationships were also strained when the ex-serving members' mental health issues meant that they had difficulty regulating their emotions or led them to withdraw from family contact. Participants also described feelings of anxiety about how to manage the ex-serving member's behaviour and uncertainty about what would trigger conflict or how much they could push the ex-serving member to communicate or seek help. Even in the absence of major relationship conflict, family members could be burdened by their role as carers; this is evident in the following case study.

Challenging transitions: 'I've had to do it all alone ... I've just had to be strong'

Elizabeth's husband Barry suffered from posttraumatic stress disorder (PTSD) and depression for nearly 10 years before he was medically discharged in his late 40s. Barry had hoped that he could stay in service until retirement age and neither he nor Elizabeth had really planned for him to leave the ADF or thought about what would come afterwards. Eventually, however, Barry's health issues led to him being medically discharged. When this happened, Barry's worsening mental illness meant that he did not have the capacity to seek civilian employment and would not do so for the foreseeable future.

The first 18 months after discharge were especially difficult. Barry had a very short fuse and was frequently uncommunicative. He received an invalidity service pension and a DVA Gold Card, which provided the family with crucial financial security, but Elizabeth described the process of applying for DVA support to be stressful and 'scary'.

Eventually, things got better and Elizabeth's husband had fewer major PTSD episodes. Elizabeth also had ongoing support from family and friends, joined a church and regularly went to the gym. She described these social contacts as essential to her mental health as well as an important source of practical support. Nonetheless, Elizabeth's family were still struggling. Barry saw a psychiatrist every three months but did not believe it was helpful. He did not access any other support services, in part because he did not know what was available. Barry continued to avoid most social contact and frequently felt unsafe when away from the house. He spent his time doing odd jobs around the house and listening to music in a granny flat he built in the backyard. Both of Elizabeth's children have had issues with anxiety and depression and saw a private psychologist. The family did not access (and were unaware of) any other support for the family.

Elizabeth was the family's main source of emotional and practical support. She monitored Barry's condition and often stayed home with him to make sure he felt safe. She provided emotional and practical care to the children and, among other things, organised their mental health care. Although Elizabeth is resilient and resourceful, she sometimes found her role as the family's primary carer to be exhausting and could feel trapped by the need to stay at home to look after her family. She was also still angry at what she perceived as a lack of support for her husband while he was in the ADF and a lack of interest in what happened to him or his family after he left. Thus, although she had a strong and supportive social network, Elizabeth often felt that she was 'on [her] own'.

Difficulty in finding stable or satisfactory employment after leaving the ADF was the other most prominent form of transition challenge emerging from participant accounts. Such difficulties were often, but not always, related to the ex-serving members' mental health at the time of transition, with several participants suggesting that their partner's difficulty finding work had been a causal or exacerbating factor in their mental illness. As with the health issues described above, ex-serving members' inability to find or stay in civilian employment could have serious effects on family finances and relationships. When describing her husband's struggles to find work, one

female participant described the family's life as 'stuck' and explained how her husband's lack of permanent, full-time employment had exacerbated the symptoms of his PTSD, led to financial stress, risked the loss of the family home and generally hindered the family's ability to build a post-transition life.

We're just surviving ... we haven't been able to move on and flourish. (Partner of voluntarily discharged member)

Ex-serving members' health challenges and difficulty finding work could also lead to, or exacerbate, other forms of difficulty adjusting to civilian life. One participant suggested that her daughter had found it difficult to find a new sense of purpose or place in the world after her medical discharge had ended her dream of a military career.

That's the hardest part with transition to real life, that it's a completely different world. Really is a completely different world. (Parent of medically discharged member)

Several participants similarly used the phrase 'different world' to emphasise the major adjustments that transitioning members and families had to make when leaving Defence life. In particular, ex-serving members were commonly described as missing the sense of shared purpose and the comradery of life in the ADF. This sense of loss appeared to be exacerbated when ex-serving members were unable to build or sustain social networks – especially of other ex-serving members – that could offer meaningful emotional support. Some partners of ex-serving members reported losing their own social networks when their partner transitioned, especially when they had moved away from family or social networks, and described the difficulties of building new social relationships with people who had not experienced the 'different world' of Defence life. These feelings of isolation seemed most marked in families who had experienced a 'challenging' transition due to ex-serving member health issues or unemployment. Feelings of isolation could also overlap with perceptions that the family had been 'cut off' or 'forgotten' by the military community after the member's discharge.

The practical aspects of reintegration into civilian life, and the loss of Defence assistance with life essentials such as housing or health care, were also particularly stressful for families dealing with other major life challenges. Ex-serving members and their families who did not have their own homes before the transition reported difficulties adjusting to the costs and complications of the private rental market or with 'learning to become home owners' (partner of medically discharged member) and dealing with house maintenance and the costs of ownership. Accessing post-transition supports could also be challenging. Ex-serving members with serious mental or physical health issues were the most likely to access medical and/or counselling services simply because of their higher needs. However, as the case study describing the experiences of Elizabeth and Barry showed, some ex-serving members with

relatively high needs accessed a limited range of services, either because they did not know what services were available or because their health issues had reduced their capacity or inclination to seek help. The process of making DVA claims, in order to fund access to services, was also regularly cited as a challenge due to the paperwork involved and the sometimes drawn-out process of receiving DVA recognition of complex claims. As a result, some participants indicated that they and/or the ex-serving member believed that the claims process could exacerbate existing mental illness and was better avoided.

The amount of bureaucracy that was involved with the whole process was so high that in the end it was deciding between my husband's sanity and moving on and leaving it all behind him ... So, he decided to just drop it. (Partner of medically discharged member)

Not all the family members participating in this study experienced such challenges nor did they necessarily find such challenges to be insurmountable. The family of ex-serving members who had relatively good health and who had moved relatively quickly into secure employment or financially secure retirement reported fewer challenges in building a post-transition life (see the discussion of transition goals in Section 8.3) or felt relatively able to manage the challenges they did experience. The forms of family support and family involvement in transition planning that are described in later chapters could also mitigate or reduce transition challenges for ex-serving members regardless of their health or employment status.

8.2 Other factors in transition experiences

The ex-serving member's mental and physical health was clearly a major theme in family accounts of their transition experience; this finding was unsurprising given the deliberate oversampling of families with an ex-serving member who had experienced mental illness and/or medical discharge. However, participant accounts also described a range of other social or structural factors that they saw as shaping their experience of transition and influencing what they had done to manage the process. These included the following:

- life circumstances (e.g. socio-economic status, life stage)
- transition type
- family and social supports
- job readiness (and professional networks)
- access to services
- transitioning into Reserves.

Family accounts of these factors are summarised below. The discussion for each factor here is relatively brief and is primarily intended to contextualise the actions that families took to improve their post-transition lives. An investigation of the relative influence of these factors, or the causal factors determining ‘good’ or ‘bad’ transition outcomes, was beyond the scope of this research and would require a much larger, focused study. Participant accounts suggested that the effects of such factors tended to be dependent on their interaction with other factors and contexts.

The contextual factors described here were perceived as largely outside the immediate control of ex-serving members and their families. However, participants did perceive some of these factors as potentially influenced or mitigated by their own actions. Where relevant, this is noted in the discussion below and in the following chapters.

8.2.1 Life circumstances

The most obvious mediating life circumstance – and the most obvious risk factor for a challenging transition – was the ex-serving member’s physical or mental health. As described in the previous section, members with poor health tended to have higher needs and this in turn could be associated with difficulties accessing help and with strained family relationships. However, participants also referenced a range of other life circumstances when describing family and ex-serving member outcomes and the type of support that families could provide. For example, some study participants with relatively high socio-economic status (associated with high rank or higher education of the participant and/or the ex-serving member) described themselves as having the financial, personal or social resources to build a financially secure post-transition life and, where necessary, to secure access to services.

Every family’s different and I think that because we didn’t have financial pressures, [that] made it a lot easier, the transition. (Partner of voluntarily discharged member)

Some of these participants also felt that the ex-serving member’s high rank equipped them with the skills or social connections to help them negotiate the exit from the ADF on their own terms. However, within this study’s small and highly varied sample, high socio-economic status was not unambiguously associated with better outcomes. Some families with an ex-serving member of lower rank also reported good outcomes while some families with an ex-serving member of high rank, or with significant financial resources, had struggled due to illness or difficulties in maintaining their pre-transition lifestyle.

Other life events, such as when other family members became ill or lost their jobs, as well as the life stage of the family, were also perceived to have an influence on the quality of a family’s life during and after discharge. Some families, for example, noted their ‘luck’ in having adult children, and thus a reduced financial and care burden

during transition. Again, however, there was no clear causal pattern linking such circumstances to transition outcomes.

8.2.2 Transition type and circumstances

The member's reasons for leaving the ADF were closely related to the family's life circumstances and similarly influenced transition expectations and outcomes. Specifically, participants whose family member had been medically discharged due to a serious health issue tended to have more challenging transitions than those where the member had discharged in order to achieve specific life goals.

However, it was not inevitable that medically discharged members had worse outcomes than voluntarily discharged members. Some medically discharged members and their families managed to mitigate the effects of their health issue through careful planning and were able to find jobs, or retire, and 'move on' from their ADF career. In contrast, some ex-serving members who had voluntarily left the ADF found it difficult to reintegrate into civilian life, particularly when their decision to discharge was relatively impulsive (and thus unplanned) and/or was motivated by their experience of significant workplace conflict or dissatisfaction. Further, the types of serious health issues that influenced transition and post-transition life were not exclusively associated with medical discharge. Some participants reported that ex-serving members who had voluntarily separated from the ADF had significant physical or mental health issues that had either not been medically diagnosed at the time of transition, had manifested after transition, or had been a factor in the ex-serving member's decision to voluntarily leave the ADF before a medical discharge became necessary.

8.2.3 Family and social supports

Participants suggested that the presence of social or family support was an important asset when transitioning and could alleviate some of the effects of major life challenges. Family or social supports could be a source of emotional support, provide child care, assist around the house, help family or ex-serving members with finding work, and help with making DVA claims (especially when the help came from other ex-serving members). In contrast, the absence of such networks could aggravate pre-existing challenges. In particular, families who had moved frequently before transition, who had transitioned in a location far from social supports or who did not have close family could lack well-established local friendships or social supports. This could leave them feeling isolated and lacking in practical or emotional sources of support. In some instances, engagement in volunteering, church or sporting groups or in ex-service organisations such as the Returned and Services League (RSL) or Mates4Mates had enabled ex-serving members and their families to build or enlarge social networks, even in the absence of other longstanding social supports. Ex-service organisations, in particular, were described as providing a network of people with similar experiences who could provide understanding and support.

8.2.4 Job readiness

The challenges of finding civilian work were a recurring theme in family narratives about post-transition lives and quality of life. Finding productive post-transition work was seen as something that was at least partially within the control of ex-serving members and their families. The following chapters outline some of the ways in which families tried to enhance the ex-serving member's job prospects. However, families also described several external barriers to ex-serving members finding work; these included the nature of their ADF service. Ex-serving members, for example, who had struggled to find work – particularly after long careers in the ADF – were described by their families as being ill-prepared for the civilian workforce.

When it came to him getting out of Defence, he had no idea. He was so caught up in ... everyone else controlling his life and his career and telling him where to live, and what to do and what job he was going to do. He really had no idea. (Partner of voluntarily discharged member)

Participants also suggested that ex-serving members who lacked a transferable trade or professional qualification could struggle to find work because civilian employers commonly did not recognise their ADF skills or experiences and/or believed that ex-serving members were too inflexible.

We were lucky that my husband had a trade ... If you're a grunt, the courses you've done don't mean diddly squat to an employer. (Partner of voluntarily discharged member)

Alternatively, for ex-serving members with a professional or trade qualification, or senior management experience, ADF service and experience could be a positive asset. Professional networks acquired through service also emerged as a crucial asset and contributor to job readiness. The ex-serving members described in this study who found civilian employment soon after discharge had almost invariably drawn upon professional or social networks built during their time in the ADF or had moved into Defence-related work.

'Who you know': finding work and moving on

Mary's husband Jack left the ADF in his late 40s because he was tired of spending time away from his family and wanted to change jobs while he was still young enough to start a second career. When Jack made this decision, the family was in a relatively good place. The family owned their own home and had significant savings. Jack was healthy and earned a good salary as a senior officer. This alone eased some of the pressure of transition. However, despite their financial resources, Mary and Jack could not countenance the idea of him leaving the ADF without a job to go to. So, the search for a new job began very early.

He was putting out feelers, I would say for about an 18-month period before he decided to transition.

Jack had acquired a range of presentation, writing and management skills during his time as a senior officer in the ADF and he put these to good use in his job search. His social and professional network was equally important. Long before giving notice, Jack had begun speaking to his network of ex-ADF friends and acquaintances in private industry and the commercial world. This resulted, almost immediately, in several job offers.

Jack was also owed long-service leave and he was able to use his position and management skills to negotiate to use his leave (including taking leave without pay) to start work in his new civilian job before he had officially left the ADF. Mary described this as a ‘fantastic way to transition’ because it not only allowed an overlap between ADF and civilian jobs but gave the family the security of knowing that if the civilian job did not work out, her husband had the possibility of staying in the ADF. Ultimately the new job turned out to be a good move for Jack and for his family: Jack was happy in his new role, the family adjusted to living together again and they have ‘never looked back’.

8.2.5 Access to external supports: service eligibility and service responsiveness

It’s bad enough to have the mental health issue, then there’s the added burden of the administration. (Partner of medically discharged member)

Participants generally saw access to appropriate support services – such as medical specialists, psychiatrists or counsellors from the Veterans and Veterans Families Counselling Service (VVCS) – as a protective factor for ex-serving members and/or their families. In particular, empathetic counsellors or doctors were perceived to improve (or at least not impair) the outcomes for those receiving treatment and for their families. Conversely, lack of access to services or supports, or treatment from health professionals who were perceived to be unsympathetic or uninformed about the military context, were regular elements in accounts of challenging transitions.

Reported service use among the study sample as a whole was uneven. The reasons for inconsistent service use are beyond the scope of this study and family members often found it difficult to articulate why the ex-serving member did not access specific services or what services were available. However, family narratives described a complex mix of culture, personal inclination, mental illness and lack of information as potential barriers to service use. For example, ex-serving members who were reluctant to seek help for mental health issues were described as both fearful of the social stigma attached to mental illness and as inculcated in a military culture of self-reliance, unwillingness to admit to weakness and lingering fears of being perceived as a ‘malingerer’.

A lot of them, as a group even, just mistrust, I think they still think there’s a little bit of a, maybe like a rank structure thing there, you know, you don’t tell tales, you don’t go up the line because you’ll get burned ... I couldn’t really put a finger on it, it’s not my culture to be like that You know, I’m a big fan of, you know, if you need help, go out and get it, there’s plenty of places to get it, and keep going, until you find someone that can help. But I’m not really sure that that’s what their

thinking is really. I think it's the opposite. (Partner of voluntarily discharged member)

DVA support in particular had an ambiguous role in participant accounts of external supports. DVA benefits could be substantial and some ex-serving members with complex health needs or limited income relied on DVA assistance. Receipt of such benefits, alongside service pensions, could mean that some families were 'almost better off than before' (partner of voluntarily discharged member). However, as was noted in the previous section, some families felt that the process of applying and waiting for DVA support was complex, slow and the cause of considerable anxiety and distress for ex-serving members and their families. Families were also ambivalent about the value or influence of specific transition services such as transition seminars. Although seminars were sometimes appreciated as a source of information and ideas for post-transition life, the families of ex-serving members with significant health issues suggested that they rarely met their specific need for information about benefits and supports.

You know, it was just people retiring from the Defence force and you know, how you go and get another job and what you could do this way and that way, rather than okay, you have a medical discharge. This is what you're now entitled to.
(Partner of medically discharged member)

8.2.6 Transitioning to the Reserves

Transitioning out of full-time service and into the Reserves could also influence ex-serving members' (and families') experience of transition, and subsequent need for family support, but was not an unambiguous negative or positive factor. Some participants believed that the ex-serving members' involvement in the Reserves had allowed them to ease their way into civilian life and maintain a connection to an institution that had been a central part of their adult lives. Reserve service was also a source of valuable extra income, and could help ex-serving members build or maintain their social networks, existing skills and self-identity. The wife of an ex-serving member who had struggled to find satisfying work after leaving the ADF saw her husband's involvement in the Reserves as one of the few things that had enabled him to keep a sense of self-respect and connection to his former self:

I think it's still kept a bit of his identity I would hate to think how he'd have presented if he hadn't even been part of the Reserves. (Partner of voluntarily discharged member)

However, not all ex-serving members were able or wanted to keep this connection to the ADF. None of the medically discharged ex-serving members whose family were involved in the study were able to participate in the Reserves and some of the ex-serving members who had experienced workplace bullying, conflict or a perceived lack of support (especially for mental illness) were described as wanting to sever all

connections to the ADF. Others simply wanted to ‘move on’ and build a new life in the civilian world; indeed, one partner of a voluntarily discharged ex-serving member described her family’s decision to make a ‘clean break’ from the ADF as a factor in their relatively trouble-free transition experience. She further suggested that some ex-serving members ‘can make the mistake of never letting go of the apron strings’ and subsequently have trouble integrating into civilian life.

Family members could also be ambivalent about the longer-term value of continued connection to the ADF. While many acknowledged the benefits, extended time in the Reserves was also described as delaying the final transition and could mean that ex-serving members and families would face another period of readjustment in the future. For example, the daughter of an ex-serving member who had remained active in the Reserves after his (voluntary) retirement suggested that although the Reserves had initially been a highly positive experience, she was no longer ‘sure if the benefits outweigh the negatives’. In particular, she felt that her father was mentally and emotionally unprepared for civilian life and the Reserves had allowed him to delay his transition: ‘I can’t imagine dad not doing something ... I think the big thing will be when he retires from the Reserves’.

8.3 Transition expectations: What is a ‘successful’ transition?

All we really wanted ... was to find something he enjoyed doing. (Partner of voluntarily discharged member)

Participant accounts did not reveal a single type of ‘successful’ transition, nor did most families clearly articulate or define a notion of ‘success’. Rather, the life circumstances outlined in the previous sections strongly influenced what families wanted or expected from the transition as well as their assessments of how well it had gone. For example, the family of ex-serving members with major health issues were often focused on ‘coping’ with everyday life, and on minimising life crises, whereas the family of ex-serving members without significant health issues were more likely to have articulated concrete family, career or retirement objectives.

Overall, the ex-serving members’ health status and their expectations about whether or not they would work after transition tended to structure expectations about post-transition life. In particular, three broad types of post-transition career expectations emerged from participant narratives. These were:

- an expected transition into civilian employment
- an expected transition into (voluntary) retirement
- transition out of the ADF without immediate expectation of employment *or* retirement (due to health issues).

To some extent, participants measured their transition experience against these expected outcomes. Families could, for example, say whether the ex-serving member had found civilian employment or not. This employment outcome could then have a significant positive or negative influence on family life (see the discussion in Section 8.1 on the challenges of post-transition employment). The reason why the ex-serving member had sought civilian employment could also matter. For ex-serving members who had voluntarily discharged in order to seek new job opportunities, a key concern was making a career change before the member was 'too old'. For example, the father of a voluntarily discharged ex-serving member described his concern that his son would have few job opportunities if he discharged in his 50s and he had encouraged his son to 'get out and make a future for yourself somewhere else'. This father's hopes, and eventual satisfaction with the outcome, thus centred on his son discharging while still in his 30s and successfully launching a new career.

I hoped he would find something that would use some of the skills that he had but not the skills that put him in an area of danger. And I was hoping that he would find himself a secure position where he still had a bit of adventure up his sleeve but security as well. (Parent of voluntarily discharged member)

Expectations were somewhat different for the family of ex-serving members who did not feel old enough to 'retire' (and/or were not old enough to access superannuation or retirement benefits) but whose health issues meant that they were not able seek paid employment. These families generally focused on trying to 'get on with things' (partner of medically discharged member) and did not articulate concrete transition goals beyond a hope that the ex-serving member's health might improve.

Interacting with these broad career or retirement expectations were a series of life domains against which participants assessed the quality of their life after transition. The most frequently discussed topics were:

- financial security
- family life (e.g. more time with family, harmonious family relationships)
- geographic stability (i.e. reducing the number of member or family moves)
- physical and mental health
- job security and job satisfaction
- leisure time (e.g. time and money for travel or hobbies)
- community and social engagement (e.g. spending time with friends, volunteering, joining community groups)

- emotional and life stability (e.g. managing and/or reducing crisis; reducing ups and downs).

For the most part, participants evaluated their daily lives (and the transition overall) against a range of these life domains. For example, if the family was more financially secure, or had a more stable family life after transition, this could be considered a kind of ‘success’. However, the relevance of each life domain, and family expectations about them, varied according to circumstances. Almost everyone spoke of the need for financial security but what this meant in practice depended on the family’s pre-transition income, their related expectations of what a comfortable life involved, and their post-transition needs. Hence, the meaning of ‘financial security’ could range from an ability to pay the rent through to being able to have regular overseas holidays.

The degree to which these quality of life criteria had been concrete transition objectives for ex-serving members and their families also varied. The families of ex-serving members who had voluntarily retired were the most likely to have explicitly articulated financial goals and to have lifestyle goals such as travel or increased leisure time. Families who were not retiring might value these aspects but were less likely to have explicitly planned for them.

However, family assessments of the relative success of their transition – including their assessment of their relative quality of life – could be complicated by uncertainty about exactly when transition was ‘complete’. In some instances, this was because the ex-serving member was still actively involved in the Reserve forces and had not yet made a definitive break from the ADF. In other instances, service or transition-related issues, such as ill health or problems adjusting to civilian life, could continue for years after formal separation from the ADF. Definitive judgements about the success or otherwise of transition were also complicated by the vagaries of everyday life. Families could have good periods and bad, relative success in some aspects of their lives but not in others; or post-transition life could start poorly but improve, or start well but be derailed by life events. Hence, some participants found it difficult to make a final judgement about how well transition had gone and could even struggle to compare their quality of life before and after transition. One participant – whose husband had experienced workplace conflict in the year before he resigned from the ADF, and mental illness, poor job stability but improved family stability afterwards – described their post-transition life as neither all good nor bad; rather, it was ‘travelling’. The following vignette further illustrates some of these themes.

Transition ups and downs: ‘Initially, I think it went really badly’

Jill’s account of her family’s transition experiences was one of initial optimism, a long period when things went badly and, eventually, the prospect of regaining their former quality of life.

When Jill’s husband, Keir, left the ADF in his late 30s, he had a specialised and prestigious role. Keir was healthy and enjoyed his work but had decided to leave the ADF because he had achieved all his major goals and was young enough to start another career. Jill and her husband also wanted a more stable family life and hoped that leaving the ADF would allow them to move back to their home region and the support of their extended family.

Jill and Keir had discussed transition for several years before Keir eventually left. They had spent considerable time discussing whether he was ready to go and where they would live when he went. When they eventually began the transition process they had a ‘financial buffer’ of savings and Jill had found them a house close to their extended families.

However, Keir did not begin searching for a new job until relatively late in the transition process and he left the ADF without a new job in place. Jill suggested that this was partly due to bad luck, because a prospective job fell through, but she also thought it a result of Keir’s overconfidence about finding work, his overestimation of the value of his skills to civilian employers and his lack of ‘real-world life skills’ such as writing responses to job selection criteria. As it turned out, Keir managed to find work a few days after leaving the ADF but the job was not what he had hoped for.

I think he really hoped to have a position, a job, that he ... felt like he was quite proud of and that he could hold himself high and say, ‘Yes, this is what I do for work.’

Keir found his new job frustrating and ‘worthless’ in comparison to his previous role. It was also relatively poorly paid. As a result, Jill said that Keir became ‘obsessed’ with finding a new job. When this did not happen, Keir became increasingly depressed, uncommunicative and isolated from his family. Despite Jill’s advice, Keir would not consider medical help or counselling. Over time, Jill’s family began to feel the financial strain of Keir’s reduced income and they were forced to use their savings.

Four years after Keir left the ADF, the situation improved. After three years of searching, Keir found a job that he found relatively satisfying and rewarding. As a result, he relaxed, became much happier and their family life was more harmonious. The job was not entirely ideal: it regularly took Keir away from home for extended periods and thus replicated an aspect of ADF life that Jill and Keir had hoped to leave behind. Nonetheless, Keir’s job satisfaction, and regained sense of purpose and identity, made the whole family’s lives a lot easier.

9 The role of families in Defence member transition

We're surviving like any family, doing the best we can. (Partner of voluntarily discharged member)

Families performed a number of tasks, and had multiple roles, in helping ensure the relative success of transition and in keeping family life going. What family members did, and who in the family did it, varied according to the nature of the relationship, the ex-serving member's needs and the family's circumstances. Partners tended to be more directly involved in transition planning than were parents, but parents could still have an important role in providing advice, emotional support and practical assistance, especially to single ex-serving members.¹⁰ Regardless of the circumstances, families were usually an important part of transition. They helped manage the process and felt the effects when things did not go well.

This chapter provides an overview of the different forms of family involvement under the categories 'transition planning' and 'family life and emotional support'. 'Transition planning' here represents the support with decision-making and planning that families provided leading up to, and during, the formal transition process. The category of 'family life and emotional support' denotes the practical care and emotional support routinely offered by families. These are overlapping rather than distinct forms of support. Emotional support could be necessary at any stage of the transition process and some forms of support, such as encouraging ex-serving members to access appropriate services, could entail elements both of transition planning and emotional care. However, distinguishing between formal planning and general family support helps to emphasise the importance of partners and parents in maintaining social, domestic and family life over the longer term.

¹⁰ Because the study focused on partners and parents, it did not explore in depth the contributions of other family members; however, participants were, where relevant, asked to describe how other family members and friends contributed to transition and post-transition life.

9.1 Transition planning

We had lots of talks about what we would do, how we would do it. (Partner of voluntarily retired member)

The importance of planning when and how to leave the ADF, and what to do afterwards, emerged as one of the most important things that families and transitioning members could do to improve their post-ADF prospects. Family members commonly played a central role in this planning. The desire to spend more time with family or to provide children with a more stable family life were among the most common reasons cited for voluntarily leaving the ADF and families had often discussed these aspects of their lives for several years before the ex-serving member discharged. Partners and parents were also commonly joint decision-makers, a ‘sounding board’ for members weighing up their options or active proponents of discharge. The value of families being involved in this kind of decision-making is further discussed in the following chapter.

In addition to ongoing discussions about when to leave, and why, families were also involved in more formal planning. This could include:

- listing the pros and cons of leaving the ADF
- explicitly articulating post-transition life goals and how they might be achieved
- listing practical post-transition needs (e.g. for services, medical assistance, accommodation)
- calculating how much money was needed for retirement or financial security.

Some participants saw this kind of family discussion and explicit joint planning as a normal part of family life – as ‘what families do’ – but it was also depicted as evidence of both a healthy relationship and a well-considered decision taken for the good of the family.

We’re a team. We’ve been together for a long time. We have immense love and respect for each other and we just know when things get to be done, we communicate well with each other ... the split of duties ... between us was half an hour of conversation, writing a few things down, ‘yes, I’ll do this and you’ll do that’. And then just getting things done, making sure that when we move, you know, what are we moving to, where are we going to be, where is my daughter going to go to child care, and then trying to start a new life, you know, establish new connections ... so yes, absolutely I helped but then my husband did too so I don’t really see myself doing anything that is extraordinary. (Partner of medically discharged member)

Family members (and partners in particular) also performed a range of the practical tasks required to arrange the family's immediate post-transition life, including finding post-transition accommodation and enrolling children in new schools. Another common theme in the interviews was the need for family assistance with paperwork, applications for benefits, and collecting and copying medical records.

I had to photocopy all of [my husband's] medical documents myself. That took me four and a half hours, tracking down previous MRIs and X-rays and things like that. Yeah, there was a lot of paperwork that had to be done. (Partner of medically discharged member)

Again, participants described this kind of support as simply what families do, but the types and intensity of involvement varied according to circumstances, need and family dynamics. Partners who described their relationship as characterised by openness, good communication and shared responsibility for decision-making suggested that this was a key factor in their involvement. However, some participants also noted that mental illness or psychological distress could reduce the ex-serving members' ability to maintain such communication or to plan ahead. Usually, this meant that family members took on a greater share of the planning burden. However, in some instances it could lead to family members being excluded from planning or having to quickly make major life decisions because the ex-serving member had made an impulsive decision to discharge.

'I was the support network': planning for the family

Zoe's husband Ray made a relatively impulsive decision to discharge from the ADF. His decision to leave was the end result of his ongoing physical and mental health issues, increasing dissatisfaction with work and a perceived lack of support from colleagues and his chain of command. Ray had previously talked about leaving, and he and Zoe had had some general discussions about what they might do after he left, but Ray's eventual decision to discharge came as a surprise to Zoe. Because Zoe and Ray had not really planned what they would do after transition, they had to move quickly to put their lives in order.

Ray was able to secure a civilian job before he discharged, and this helped ensure the family's short-term financial security, but there was still a lot of planning and organisation that had to be done very quickly and much of this fell to Zoe. Zoe described life in the ADF as a form of 'controlled environment', in that the family had been provided with housing, security and a social network, and subsequently the family had to adjust to life without these supports. In this phase of the transition, Zoe felt that she had to 'be the level head' and get Ray to slow down and think through what the family needed to do next, and what parts of their life they would need to change or put in order, so that 'things didn't hit us like a ten-ton truck'.

He was kind of a bull at a gate, 'let's go', whereas I was like, 'Well hang on, we need to do this, we need to do that ... you've got the kids to think about'.

As part of the transition process, Zoe also took control of the family's finances, investigated Ray's superannuation and pension benefits, read all the transition information provided to Ray by Defence and DVA, spoke to DVA on Ray's behalf and pushed him to get help from the RSL and engage an advocate.

I would do research if we wanted to know stuff, and then I would sort of put the piece of paper under his nose and say, 'Well have you checked this out, have you spoken to these people?'

Throughout this time, Zoe also provided crucial emotional support to the whole family; she described herself as having to act as a 'calming force' amidst the disruption brought about by Ray's impulsive decision to discharge. She had to support Ray and provide stability and reassurance to their children.

Ray's transition proved to be challenging for the whole family because of its rushed nature and, in the longer term, because of Ray's mental health issues and difficulty adjusting to the civilian workforce. However, Zoe's efforts to think through what the family needed to do to survive, her active search for useful information, services and supports, and her ability to emotionally support Ray and their children, meant that the family was able to cope with the ups and downs of this major life transition.

For a small number of participants, detailed planning was seen as largely unnecessary because the transition was expected to be (and ultimately was) straightforward. For example, one participant suggested that there had been minimal need for planning because her family's circumstances at the time of transition meant that their life would not significantly change: the ex-serving member had found civilian work long before his discharge, he had no significant health issues and the family already owned their own home. Hence, their life went on much as before.

Family members also varied in the specific experiences and skills that they could bring to bear on transition and transition planning. Partners and parents with extensive administration or management skills, for example, were often better able to help transitioning members identify appropriate civilian jobs, rewrite their CVs or promote themselves to civilian employers. Some also described how they had leveraged their professional networks to introduce the ex-serving member to potential employers.

Although many participants reported involvement in transition planning, relatively few family members had been in contact with specifically transition-focused services or with ex-service organisations (either for themselves or on the ex-serving member's behalf). A small minority of family members had attended transition seminars and/or had been in contact with other transition-related services (such as member advocates). Most participants, however, were unaware that family were allowed to attend transition seminars and had a limited sense of what support services were available. Participants tended to describe this part of the transition process as part of the ex-

serving member's work domain and, as such, families were either not required or not welcomed.

9.2 Family life and emotional support

Participant accounts of their involvement in transition extended beyond planning for discharge and commonly emphasised the importance of emotional support and their role in sustaining relationships and preserving family life through difficult times.

Like we all do, just keeping that fire burning really, and just being a bit of a support and a sounding board when things need discussing. (Partner of voluntarily transitioned member)

As with family involvement in transition planning, the degree of emotional and practical support that participants provided tended to vary according to the family's circumstances and the difficulty of the transition. A small number of participants, whose ex-serving members had experienced a relatively trouble-free transition, described their involvement as essentially that of general support and of backing the transitioning member's decision to leave the ADF.

I didn't have any role other than just to support him and support his decision ... and ... pick his civilian wardrobe. (Partner of voluntarily transitioned member)

Unsurprisingly, more challenging transitions required more intensive family support. The family of ex-serving members with significant physical or mental health issues could be required to provide ongoing assistance with physical care, such as mobility or personal hygiene, and/or to assume significant responsibility for managing family life. This could include organising the ex-serving member's social life, taking responsibility for paying bills and managing the family's finances, financially supporting the family, performing most domestic tasks and providing emotional care for other family members (especially children). Other forms of practical support included encouraging the ex-serving member to seek counselling or medical help, researching or contacting appropriate support services, helping to complete DVA claim forms, providing transport to appointments, and speaking to DVA, support services, and/or medical and health professionals on the ex-serving member's behalf.

He actually would ring them and say, 'I'm not talking to you, you need to talk to my wife.' So I'd have to relay because ... he just couldn't deal with them anymore. (Partner of voluntarily discharged member)

However, family attempts to encourage ex-serving members to seek help were not always successful, particularly when family members lacked knowledge of what supports were available.

I really don't know what we're entitled to ... I'd like more, I would have liked more information from DVA when we transitioned to say, 'These are the avenues we can help you with', because the only avenues I got with them are the ones that we had when we were current [serving]. (Partner of medically discharged member)

Some participants also described their uncertainty about whether or not they should encourage ex-serving members to seek help. In particular, some family members reported their concern that pushing ex-serving members to seek professional help or talk about what they were feeling could result in conflict or make the ex-serving member relive traumatic experiences. Indeed, some family members wondered if the best thing they could do for ex-serving members was to 'give them space' (partner of medically discharged member). Such uncertainty was particularly an issue when the family member felt that they had insufficient understanding of an ex-serving member's illness to be able to determine the best course of action. Nonetheless, many participants, especially the partners of ex-serving members with a mental illness, felt that it was important that they 'keep talking' (partner of medically discharged member) and try to understand what the ex-serving member was feeling and why.

Whether or not they were able to facilitate access to services or professional help, many of the family of ex-serving members with mental health issues (especially those with PTSD) reported that they actively monitored ex-serving members' moods and psychological health. This could also entail learning when ex-serving members might be 'triggered' or struggle with the symptoms of mental illness. In some cases, families adopted specific routines to deal with these symptoms.

I keep an eye on it. I know when he's having a meltdown so I try to defuse the meltdown but if it's too bad ... I just say, 'Okay, off you go, go outside. Go into your workshop. Take it out on the workshop.' So, he goes out and plays, throws the ball for the staffy and she chases it around the yard. (Partner of medically discharged member)

Some participants also reported that they modified their own behaviour, or that of their children, in order to avoid PTSD triggers or family conflict. This could mean avoiding difficult topics, walking away from arguments, helping members avoid public spaces by doing all the shopping and other domestic duties outside the house, and generally curtailing the family's social life. Although this kind of behavioural and emotional management was described as an important way to support ex-serving members, as well as a way to protect children from conflict, it could also be emotionally taxing; one partner of a member with PTSD described it as 'walking on eggshells' (also see Section 8.1).

Beyond the ex-serving members' own needs, it was not generally possible to isolate particular family characteristics that predicted or enabled a particular type or level of

family support. Nor was it in the scope of this study to determine what kind of emotional support was most beneficial. However, the limited research literature on the family's role in enabling transition (or return from deployment) suggests that close emotional ties, good communication and nurturing relationships can help offset risks to transitioning members and promote resilience (Masten, 2013; Meredith et al., 2011). Participants in this study generally echoed these research findings when emphasising the importance of strong family relationships for overcoming life challenges. Participants also commonly made reference to the importance of both family members and ex-serving members being 'resilient' or maintaining a 'positive attitude'.

Keep as positive as you can and be as supportive as you can. (Parent of medically discharged member)

These qualities were variously (and sometimes contradictorily) described as the intrinsic quality of individuals, as something that could be learned and as something acquired through life experience. For example, one partner of an ex-serving member described the couple's ability to survive the emotional and physical disruption of her husband's medical discharge as both the result of their personal inclination to always 'have a solution or an outcome in mind' and as the result of their previous experience of a major life transition when they migrated from Europe to Australia.

We were better equipped than most to deal with setbacks. (Partner of medically discharged member)

However, it was also the case that the majority of partners in the study were still in a relationship with the ex-serving member at the time of the interview; hence, it is difficult to determine if such strong relationships and family functioning were protective factors in themselves or simply signs that the family was (currently) coping (MacDermid et al., 2008).

10 Improving transition outcomes

10.1 What families can do

Despite the variation in participants' circumstances and outcomes, there were strongly consistent themes in their accounts of what families (and transitioning members) could or should do to produce better transition outcomes. This included general advice about the importance of emotional support (see Chapter 9), but participants were also able to reflect on what had gone well, what had gone wrong and what could have been done better. The most common forms of advice to families experiencing transition were as follows:

- Plan well ahead, set goals and do not make rushed decisions.
- Know that finding a job can be difficult and act accordingly.
- Be informed and be proactive in seeking support; do not expect help to come to you.
- Plan for the whole family; recognise that families are affected by transition too.
- Do all that you can to understand the member's circumstances.

This general advice is discussed in more detail below.

10.1.1 Planning ahead

Don't rush into it ... do it in your own time if you can. (Partner of voluntarily retired member).

When sharing their experiences of what worked, or what they wished they had done, participants regularly reiterated the importance of careful preparation and taking time to make decisions. In contrast, impulsive or rushed decisions were described as associated with more stressful or traumatic transitions and with strained relationships. Thus, transitioning members were advised to 'hold on' in Defence for as long as possible, even when experiencing difficulties at work, in order to put plans in place. That said, some families also stated that if the workplace was intolerable then quick action, and a quick transition, could be necessary.

The ex-serving members whose families participated in this study had not always been in control of how long they had to prepare for transition and not all of them had the physical or mental capacity to significantly contribute to planning their future. Hence,

the kind of careful preparation that could be associated with good outcomes was not entirely achievable for everyone. However, when time for planning *was* possible it could mitigate even very challenging circumstances.

Starting exit plans at least 12 months before formal separation from the ADF was suggested as an ideal. Indeed, some families had discussed the possibility of transition for years before making a final decision. This long-term planning was recommended as a way of making sure the member was really ready to leave Defence and would not regret or resent their decision. Some also advised having post-transition plans in place before the member gave formal notice (when leaving voluntarily).

There were a number of ways in which this ‘planning’ could play out in practice, but most focused on clearly thinking through all that was needed for civilian life. Most commonly, this meant thinking through where the family would live, what the member would do for work, whether the family had adequate savings, whether they knew what benefits they were entitled to, and what civilian medical or health services they might need and how to access them. A list of emergency helplines or crisis contacts was also suggested as a potentially helpful way to plan for things not going well. Physically making a list of all these post-transition needs, and planning how the family would meet them, was suggested as a helpful first step and as something that was ideally done by both partners (where relevant).

Make sure you have all your ducks in a row. (Partner of voluntarily discharged member)

As noted above, a key point in planning was thinking about where the family would live and whether couples had agreed on a preferred location. This could involve exploring whether there were sufficient medical or social services in a proposed location, whether there were social supports, friends or family nearby, whether there was time to find child care or school places before moving, and whether a location had sufficient employment, leisure or volunteering opportunities. Cost was obviously a consideration for many, especially when moving out of Defence housing, and again some families found that starting their hunt for housing early (well before moving) could ease some of the stresses of relocating. The stress of moving to a new location, and of making the many arrangements that this entailed, could also be eased if the member had managed to secure a final posting in the location where they planned to transition – which required both considerable forward planning and the support of Defence – or if the family had already settled in their planned final destination (even if unaccompanied by the member).

Organising family finances well before exit from the ADF was also described as important. Those who had seen a financial adviser had been able to set savings goals for retirement or calculate how much of a financial buffer would be needed if the

member was unable to find work. Transitioning members were also advised to obtain information about entitlements well before discharge because doing so amidst the distractions of the actual transition could be stressful and the information more difficult to come by. Applying early for benefits or income support could also mitigate the risk of a long wait for an outcome. Such applications could potentially be facilitated by the use of support services as such as DVA's On Base Advisory Service or by advocates, although not all participants found such assistance helpful in every instance.

Families were also advised to make their own copies of medical records, and organise them well ahead of time, for use in supporting applications for DVA recognition or for transferral to civilian medical services. Such records could be difficult to obtain after discharge and were not always transferred efficiently between services. Having personal copies could mitigate the risk of records going missing.

'We had a plan and worked to that plan'

Fiona and Allan faced a range of challenges in the lead-up to Allan's retirement from service and in their life afterwards. Before his voluntary discharge, Allan had become unhappy at work. He did not enjoy the office politics and found the work increasingly difficult and stressful; this difficulty was exacerbated by the symptoms of his PTSD (diagnosed several years before). However, the final decision to discharge was not made hastily but rather was the culmination of Fiona and Allan's years of planning about how to ensure a comfortable and financially secure future.

We knew we had to not wake up the next day and say, 'What do we do now?'

Part of this planning had included Fiona and Allan ensuring that they agreed on their retirement goals. Many years before Allan's discharge, they had written 'wish lists' of where and how they wanted to retire. In particular, they made sure that they had shared expectations about their post-transition financial security and quality of life. They also had a shared desire to travel and to spend time together in a way that had not been possible while Allan was still in the ADF.

To make sure that they live the life they wanted after Allan's retirement, Fiona and Allan had carefully planned for their financial future. More than a decade before Allan voluntarily discharged from the ADF, he and Fiona had used some of his deployment money to buy an investment property. Over the next decade, both also worked toward making their retirement goals a reality. They saw a financial planner, salary sacrificed to increase their superannuation and worked out the specific amount of savings that they would need to ensure a comfortable retirement.

We're both pretty organised and I mean, we're pretty pragmatic ... we were educated in the sense of, you know, understanding money.

When Allan eventually decided to discharge (in his 50s), it was prompted by the couple reaching their savings goals as much as it was by Allan's dissatisfaction with work or his mental health

issues. Almost immediately after discharge, Fiona and Allan began their planned travels around Australia. Eventually they settled in the house that they had bought as an investment property and used Allan's recently accessed superannuation to pay off the mortgage.

The transition was not without challenges. Fiona felt that she had to cope with Allan's PTSD without much external support or knowledge of how she could best support him. Allan's condition at times had strained their relationship and could limit his ability to engage with family or friends. However, Fiona and Allan were financially comfortable and settled in their community. Both were involved in community and volunteer work. Given Allan's health status, his transition went as well as he and Fiona had hoped and planned that it would.

10.1.2 Planning a civilian career

Families advised that it was important to acknowledge that finding a job and starting a new career can be challenging and that members and their families need to plan accordingly. Many of the planning principles summarised in the previous point applied here too; in particular, the need to avoid hasty decisions such as resigning without a viable plan for alternative employment. Even in the best circumstances, transitioning members could still be challenged by the demands of a new civilian job, but leaving the ADF with a job already arranged had obvious financial and psychological benefits.

Planning for a career change was described as ideally starting before transitioning members actually started looking for new work. An important early step, that some ex-serving members had struggled with, was determining what job the member wanted and how realistic their hopes were. This could involve exploring how transferable the transitioning members' skills or qualifications were, what civilian jobs might match their military experience and whether they needed to undertake further training to increase their employment options. Not all ex-serving members had been able to do this career mapping work alone so it was often undertaken with the assistance of their family. The potential usefulness of professional career guidance and coaching was acknowledged, but few in the study sample reported obtaining this.

Finding a suitable job, even for those with transferable skills or qualifications, could take some time so beginning the search for jobs, and contacting potential employers, early could ease later stress and financial concerns. Such advice is not unique to military transitions: it largely reflects the advice given in DVA transition materials and was described by one participant as 'nothing that a career counsellor in Year 12 isn't going to tell you' (partner of voluntarily discharged member). However, as that participant also noted, such 'common sense' advice can easily be forgotten by people who have not recently (if ever) applied for civilian employment.

In many instances, there was a long wait between notice of discharge and formal separation from the ADF; this transition period could be further extended when members used their accumulated leave. For some members, this time proved to be

beneficial because it gave them time to search for employment. However, some members were reluctant to look for work if their long transition period meant that they could not accept a job when it was offered (and when acceptance was time critical). To get around this, some ex-serving members had negotiated permission to start their civilian employment before formally leaving the ADF. This allowed them to accept jobs when they were offered and enabled a less abrupt transition. The ability to have this flexibility around work and exit, however, appeared to depend in part on the support of the individual's chain of command and on their ability to advocate for, or negotiate, such conditions.

10.1.3 Proactively seeking support

It's a big organisation and there are people out there who will be helpful, they're just hard to find. (Partner of voluntarily discharged member)

For services and supports to be helpful, ex-serving members and families had to access them. This required them to be willing to seek support, find what they needed and be able to pay for it. Although DVA could facilitate service access and payment, participants commonly suggested that if families want help then they need to get it for themselves. Such claims were sometimes intended as a criticism of Defence or DVA services, but they were also intended to be a form of advice – that is, that families facing the prospect of transition need to be informed, proactive and take responsibility for seeking help. Although some ex-serving members had their service access (or applications for DVA support) facilitated by independent advocates, rehabilitation consultants or case managers, others had done their own research to find out what services or entitlements they were entitled to and did what was necessary to receive them. Those who had not done such research were not always aware of what services or supports were available.

You need to be on top of those sort of things. Because they're not going to be offered to you. (Partner of voluntarily discharged member)

There were a range of opinions about the value of specific services such as the Veterans and Veterans Families Counselling Service (VVCS), advocates or ex-service organisations. Although some found them invaluable, others had less satisfactory experiences and had stopped using them. However, most participants stated that being informed about what supports or services were available, and trying them out, was important. The same was said of transition seminars and transition information packs. Although there were mixed reports on their usefulness, transitioning members and their partners or parents who had read the provided transition literature and/or attended seminars had generally been better informed about what transition supports were available.

You've gotta do those seminars. They are full of information that may or may not help or may or may not spark other ideas for you. So, it's worth doing them anyway. (Partner of voluntarily discharged member)

10.1.4 'Plan for the whole family'

It's not just one person in it. (Partner of voluntarily discharged member)

Those couples (in particular) that acknowledged from the start that families are involved in, and affected by, transition were better able to plan and make effective joint decisions that benefited the whole family. In contrast, when decisions were made without significant family input, both the transitioning member and their family could be carried along by circumstances and have little time to consider their options.

He chose the direction we were going and we just had to sort of follow, and support each other basically. Just try and deal with it as best we could ... at the end of the day, his decision to leave was the main decision and we just had to go with that. (Partner of voluntarily transitioned member)

There were a range of ways in which families could be effectively involved and acknowledged. Relatively few participants had been to transition seminars, or even knew that they were able to, but those who did were better informed about potential transition issues and available services. Having a partner or parent read the available transition information, and attend the transition seminars, also meant that the family was not solely reliant on the transitioning member to remember or relay potentially crucial information that could affect the whole family.

Open communication between partners about their goals and aspirations could help in decision-making and reduce the risk of later disagreement. It was also important for families managing the effects of mental illness or a traumatic transition experience. Participants suggested that being 'open', 'loving' and regularly communicating were not only the qualities of a good relationship but also something that families could work on and that would facilitate more effective emotional support.

Talk to one another. Talk about where to go, what to do. (Partner of medically discharged member)

Actively supporting the family's social and emotional wellbeing, and not just that of the person leaving the ADF, was also believed to be essential. This could mean taking the family into account in transition decisions as well as accessing services that support family members. Some participants also suggested that family members who practised self-care could more effectively help their families and keep family life going. Relatively few participants had sought formal help, such as counselling, for themselves; in part because many did not know what was available or because they were focused on caring for other family members. However, those who did seek counselling (either privately or from VVCS) mostly found it of benefit. More commonly, family members

benefited from (and sometimes relied on) supportive social or family networks who could provide support, advice or care. Where such social networks were not readily available, involvement in external activities, such as work, volunteering or leisure activities, could be a partial substitute.

I think it's really important that a family get psychological help ... put things in place for yourself and your family so they are not on their own like I was. (Partner of medically discharged member)

10.1.5 Understanding the member's circumstances and the challenges of transition

Family members commonly suggested that one of their most important roles was to provide non-judgemental support and validation of transitioning members' feelings (also see Section 9.2).

Always be supportive, no matter what. (Partner of medically discharged member)

However, such support was easier to provide when families had a better understanding of what the transitioning member was going through. Many of the participants who had experienced a 'challenging' transition had little prior knowledge of the challenges that they would face and were unsure of what to do or where they could turn for help. Such a lack of knowledge was described as an additional source of anxiety, as well as a hindrance to better transition planning. Subsequently, family members suggested that being aware of potential transition (and health-related) challenges could be empowering and enable families to provide more effective support.

For some, the challenges they faced were relatively limited in scope: readjusting to family life and raising children with a partner who had previously spent extended periods away. Knowing that these could be an issue was described as potentially mitigating the effects of transition and allowed partners to work together to overcome any sense of dislocation. However, sometimes the learning curve was steeper, particularly when the ex-serving member had significant health issues. Families who did not know what to expect when a member had a mental illness could find life difficult and unpredictable. Participants reported that their knowledge of how hard it could be for the member to find work, the effects of the loss of a military identity, why symptoms manifested as they did, what triggers to avoid, and how hard to push members to communicate, socialise or even leave the house was mostly won through experience. For some, this experience had allowed them to reach a kind of equilibrium where symptoms could be managed and life could go on.

Yet many still indicated that even after an extended period, they still lacked the knowledge to know whether they were doing the right thing, or whether they had pushed the transitioned member too hard or not enough. These family members

indicated that had they known more, had they understood more, they might have been able to avoid some of the conflict and discord they experienced and been better able to tolerate member moods, manage behaviour and seek appropriate help.

I don't think I understood the extent of the anxiety and its impact which then I feel, I guess, a little bit ill-equipped ... I guess I, you know, being really honest, kind of underestimated also the impact, the loss of the career. (Parent of medically discharged member)

It is unclear whether greater understanding of the possible symptoms of mental illness would necessarily produce better outcomes or make things easier for families. Nonetheless, family members suggested that greater knowledge of what to expect when a member had a mental illness could reduce their feelings of powerlessness and give them greater confidence in taking action.

10.2 Family desires for support

In outlining their experiences of transition, participants made a number of suggestions about how families could be better supported. In most instances, what participants said they wanted was for Defence or DVA to provide more targeted, individualised support for the transitioning member, particularly when they were medically discharging. Participants' knowledge of what supports and services were available was inconsistent; indeed, some wished for supports or services that are already available. In particular, family members expressed a desire for the transitioning member to have career guidance, case management or assistance with navigating DVA systems and paperwork, while others wished for more family counselling. These are services that do already exist, at least in some places and in some circumstances, and some participants in this study had been able to access them. This therefore suggests potential issues with the effectiveness of communication with transitioning members and/or their families about appropriate services.

Family members – particularly those whose child or partner had experienced a challenging transition – also commonly expressed a desire for acknowledgement of the role that families play in transition and wanted more support for, and communication with, families. The three areas they most wanted assistance with were:

- better transition preparation for transitioning members and families
- more effectively targeted communication with families
- more proactive service provision.

These forms of assistance are discussed below.

10.2.1 Better transition preparation

The efficacy of Defence's (or Defence-contracted services') preparation of members for transition was raised as an issue by participants when they spoke of the difficulties that some ex-serving members had experienced when trying to adjust to civilian life. Specifically, they suggested that more targeted, personalised and practical preparation for the challenges of civilian life would be beneficial. Some of the expressed concerns about member preparation also related to the transferability of skills learned in Defence and the expectations of work life that had been instilled by experience of Defence roles and command structures.

He found civilian life hard, making the adjustment from ADF life, where things are very structured and rules orientated, to civilian life where work is different, he found it hard to adapt. (Partner of voluntarily transitioned member)

Some felt that because of this previous work experience, and transitioning members' lack of civilian 'life skills', that transitioning members needed more practical assistance in preparing for life after the ADF. Such assistance was commonly couched in terms of more help with job preparation and career guidance, but there were also expressed desires for more advice and information about the effects of transition on families.

The family of ex-serving members who had struggled to find civilian work also suggested that transition seminars tended to place too much emphasis on the value of Defence skills or training to civilian employers and subsequently did not address how difficult finding work could be. This was believed to contribute to overconfidence and/or unrealistic expectations among transitioning members that could hinder their search for work.

These assessments were, in part, related to the member's circumstances at the time of attending the seminar or receiving transition information: members who were voluntarily discharging from the ADF as part of a planned process were seemingly better able to assimilate the information than those in more challenging circumstances. For the latter, the amount of information on offer could be 'too much' in too short a time and subsequently difficult to absorb or to share with family members. Transitioning members with a serious physical illness or mental health issues could also struggle with completing the paperwork needed to obtain DVA benefits. Hence, the families of members who had been medically discharged and/or who had a mental illness at the time of discharge suggested that more individualised and person-centred transition support, such as case management or coordination before and after discharge, would have been beneficial.

I think it was something like six weeks or something that he had – the transition period out, where he actually had support. But that wasn't long enough. He needed stuff after he got out ... you know, a whole list of recruitment agencies, he needed someone to speak to him and say, 'Okay, this is what jobs you have done

in Defence, what you're qualified for'. You know, 'Okay, you've got these jobs that are available to you – here are some connections', you know? All that sort of stuff and there's none of that. (Partner of voluntarily discharged member)

10.2.2 Clearer and better targeted communication with families

Families need to know that it's going to be hard for them. (Parent of medically discharged member)

The low reported levels of family involvement in transition seminars, and the limited awareness that families were allowed to attend such seminars, was indicative of a broader perceived sense that Defence and DVA offered limited space for family involvement and rarely communicated directly with family members. Such perceptions could overlap with a concern that the role of families in supporting transitioning or ex-serving members was largely unacknowledged and that there was limited support for families.

Wives have to deal with it and they get no support. (Partner of voluntarily transitioned member)

Because Defence or DVA were often unable to communicate directly with families, family members were often reliant on transitioning members to pass on information. This did not present a significant problem when the transition was smooth, when families (especially couples) regularly discussed their transition issues, or when family members already had good knowledge of available services. Some family members, however, felt locked out of the institutional parts of the transition process and ill-informed and ill-equipped to deal with some of the challenges they faced.

Thus, some families wanted more direct communication from Defence and/or DVA. Prominent themes in requests for such communication included advice on services in their local area, more detailed information about the issues they might face, and clear advice on how they could best give and receive support. Families of ex-serving members with more complex needs, or who had experienced difficult post-discharge experiences, also expressed a desire for more follow-up (from services, Defence or DVA) about their transition progress.

It'd be good to have someone contact me ... It's a big ask and it's resources and I'm aware of that, but if someone had actually called me and said, 'How are you travelling? How is your partner travelling? Are you coping with that ... are you managing that okay?' (Partner of voluntarily discharged member)

There was some awareness among participants that they could get useful information from the DVA website or from family sessions at VVCS. However, this information was not always perceived as actively communicated to families; rather, they felt that they were expected to find it for themselves.

10.2.3 More proactive service provision

The issue of having to find help for themselves was another recurring theme in participant accounts of service use. As discussed above (in Section 10.1), transitioning and ex-serving members and their families could feel that finding relevant information, and then accessing services, was largely up to them. Even when they had access to services, or had DVA claims in process, there was a common perception that services had to be chased if the member was to receive any help.

This perception, or experience, was not universal. Some ex-serving members had experienced few problems accessing necessary services or had had their access to a range of supports facilitated by third parties such as their doctor, unit (while still in Defence) or by DVA-funded case management services. Nonetheless, the perception that applications for DVA support were complex and stressful was evident in many participant narratives. So too was the claim that members and families often had to negotiate the links between Defence and DVA medical services themselves, often by copying or keeping their own medical records. Despite the significant benefits that DVA provided or facilitated for some ex-serving members, it was common for participants to feel that no one was looking out for ex-serving members or their families after the member discharged.

I think there's no medical follow-up around ... how they're coping, and their experience after getting out and you know, do they need any other support ... You know, contact them 6 to 12 months after they leave, 'How are you going? Do you need any other support? Do you need help, us find you a local doctor? Do you need us to help you with X, Y or Z?' But there was nothing that I could see. So, I think that's the type of support that would've been helpful. (Partner of voluntarily discharged member)

11 Discussion

This study aimed to present preliminary findings on the forms of support that families provide to transitioning ADF members and explored the ways in which this support can mitigate the more challenging aspects of transition. The study was also designed to allow the families of ex-serving members to share their experiences of what had helped them the most and their insights into what might help other transitioning members and families. The exploratory nature of the study meant that there are limits on how the results can be interpreted. The qualitative nature of the research, and the specific focus on the experiences of families who experienced a challenging transition, means that while the findings provide important insights into the family experiences of transition, the study was not intended to be representative or to identify what the majority of transitions are like. The small sample, combined with the deliberate oversampling of ex-serving member families with a high risk of a ‘challenging’ transition, also meant that the study was not designed to explore associations between particular family or ex-serving member characteristics and transition outcomes.

Overall, the study found that the range and scope of support provided by families varied, as did family notions of a ‘good’ or ‘satisfactory’ transition (if they could articulate such a notion at all). Much of this variation hinged on the different needs of the ex-serving members and their reasons for discharging from the ADF. In particular, ex-serving members with significant physical or mental health issues (regardless of whether or not they were medically discharged) tended to have more challenging transitions and required more intensive family support. These different starting points can make it difficult to judge the ‘success’ of a transition. However, participants’ focus on general quality of life issues when discussing their transition suggests that attempts to assess their outcomes could explore the use of formal quality of life measures to assess member and family satisfaction with transition and how this might change over time.

Whatever the circumstances, families were the main source of support for transitioning and ex-serving members and could suffer when things did not go well. Even when the participants in this study were not themselves the primary source of support, another member of the family usually was. Moreover, although transitioning members had different levels of need, and different families could draw on different skills or experiences, overall the types of help that ex-serving members and their families had found most useful were relatively similar across the study sample.

Specifically, early transition planning and sustained family involvement in planning were the most consistently cited strategies for achieving a good transition or for improving a difficult one. Avoiding rash or hasty decisions and thinking carefully about when the member was going to transition, where they would work, where they would live, what services they might need and how they would cope financially were key issues. However, making such decisions and plans could be more difficult when events moved quickly or when transitioning members had a diminished capacity to plan.

When asked about their support needs, families generally focused on support for the transitioning member; in particular, expressed desires for more personalised transition preparation, and for more proactive service provision, were recurring themes. However, families also commonly expressed a desire for more targeted information that could be provided directly to families. This desire reflected, in part, a widespread perception that families were often forgotten or excluded from the formal transition process. Participant concerns that they were not always well-informed about transition-related issues, or about ex-serving member health issues, were seemingly borne out by the inconsistency of knowledge about what services were available. It is beyond the scope of this study to explore whether additional or more targeted information for transitioning members or their families would necessarily lead to greater service use or better outcomes. The reasons why people do not always access appropriate services are complex and would require a focused research program. It is also important to note that participant accounts of transition support reflected their experiences at the time of the ex-serving members' transition and may not reflect transition initiatives or service changes instituted after their transition. Nonetheless, participants commonly expressed a belief that appropriate and timely communication with both ex-serving members and their families would help equip them with the tools to better manage their post-transition lives.

11.1 Summary of the research findings and their implications

- Ex-serving members with mental health issues and/or who had been medically discharged tended to have challenging transitions and require significant support from their families. The challenges could include the symptoms of the health issue itself as well as other transition challenges such as difficulty finding work or establishing post-transition social networks. The latter transition challenges were not exclusive to the ex-serving members with health issues but they (and their families) did appear to be more affected by such issues. In contrast, ex-serving members who had voluntarily discharged, had few health concerns and had arranged civilian employment before discharge, or were voluntarily retiring, had fewer support needs and their transition had less of an effect on their family.

- Families did not articulate a single definition of a ‘successful’ transition; rather, assessments of post-transition life were strongly shaped by life circumstances. For example, families with an ex-serving member with PTSD could be primarily focused on maintaining harmonious family relationships, and managing the ex-serving member’s symptoms, rather than on other life outcomes such as employment or income. Hence, when assessing the relative ‘success’ of a transition, outcome measures that look at employment, financial position or health status are valuable but not necessarily sufficient. However, families did generally emphasise general life quality issues when discussing their transition outcomes. Hence, further research on transition outcomes could use formal quality of life survey measures to explore changes in life quality before, during and after transition.
- Family assistance could generally be characterised as either: 1) help with transition planning, or 2) assistance with family life and emotional support. These were not mutually exclusive forms of support but highlight the ways in which family support mattered at different times. Simply keeping family life going could be a crucial form of support.
- Family was generally involved in all the cases explored in this study but the degree of their involvement could vary. The strongest predictor of intense involvement in the second form of support, ‘assistance with family life’, was the member’s health status and/or difficulty finding work, but most family members provided some form of emotional support. Family involvement in planning was also variable but was less clearly associated with any single factor; member health status, reasons for discharge, personalities, relationship and communication styles, knowledge and skills all appeared to play a complex role.
- Partners tended to be the family members most involved in transition planning but parents could also play a key role. Because a range of family members can potentially be important supports, it should not be assumed who the most important family members are in any specific case.
- Although investigation of the causal factors for specific transition outcomes was beyond the scope of this study, it was apparent that a range of factors could interact to increase or decrease quality of life. Some of these factors – such as the transitioning member’s health or other life circumstances – are not entirely within the control of transitioning members, families or DVA and thus cannot be entirely eliminated. However, families did suggest that some of the effects of these circumstances can be mitigated.
- The most significant mitigating action undertaken by transitioning members and their families was early planning and family involvement in planning. The

importance of planning is emphasised in DVA transition materials (such as the DVA website) but could potentially be better communicated to transitioning members and their families. A possible aid to such communication would be the use of narratives from families who have already been through this process.

- Transition information is likely to be more effective when shared with families and not just transitioning members. The low levels of knowledge about the services available to families suggests that there has not always been effective communication with families. Relying on transitioning members to relay information, or for families to find information for themselves, is also not always an optimal strategy. Because Defence currently requires member consent to communicate directly with families, alternative ways of communicating with families may need to be explored.
- The effectiveness of communication with families is likely to be increased if the information is appropriately timed and not a one-off event. Families suggested that the weeks and months leading up to discharge could be a tumultuous and stressful time so information was not always successfully assimilated by transitioning members.
- Participants indicated that more effective transition preparation for ADF members would also benefit families. In particular, the families of ex-serving members with high needs indicated a desire for an individualised model of transition support in which the transitioning members' needs and circumstances more strongly influenced the type of transition support and advice that they were offered. Case management or case coordination were proposed as models for such support.

References

- Berle, D., & Steel, Z. (2015). Families of returned defence force personnel: A changing landscape of challenges. *Australasian Psychiatry*, 23(4), 399–402.
- Bowling, U. B., & Sherman, M. D. (2008). Welcoming them home: Supporting service members and their families in navigating the tasks of reintegration. *Professional Psychology: Research and Practice*, 39(4), 451–458.
- Dekel, R., Solomon, Z., & Bleich, A. (2005). Emotional distress and marital adjustment of caregivers: Contribution of level of impairment and appraised burden. *Anxiety, Stress and Coping*, 18(1), 71–82.
- Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, 9, 477–501.
- Holmes, A. K., Rauch P. K., & Cozza, S. J. (2013). When a parent is injured or killed in combat. *The Future of Children*, 23(2), 143–162.
- Lester, P., & Flake, E. (2013). How wartime military service affects children and families. *The Future of Children*, 23(2), 121–143.
- MacDermid, S., Samper, R., Schwarz, R., Nishida, J., & Nyaronga, D. (2008). *Understanding and promoting resilience in military families*. West Lafayette, IN: Military Family Research Institute.
- Masten, A. (2013). Competence, risk, and resilience in military families: Conceptual commentary. *Clinical Child Family Psychological Review*, 16, 278–281.
- McFarlane, A. (2009). Military deployment: The impact on children and family adjustment and the need for care. *Current Opinion in Psychiatry*, 22, 369–373.
- Meredith, L., Sherbourne, C., Gaillot, S., Hansell, L., Ritschard, H., Parker, A., & Wrenn, G. (2011). *Promoting psychological resilience in the US Military*. Santa Monica, CA: RAND Corporation.
- Morin, R. (2011). *The difficult transition from military to civilian life*. Washington, DC: Pew Research Center.
- Sayers, S. L., Farrow, V. A., Ross, J., & Oslin, D. W. (2009). Family problems among recently returned military veterans referred for a mental health evaluation. *Journal of Clinical Psychiatry*, 70(2), 163–170.

- Tanielian, T., & Jaycox, L. H. (Eds.). (2008). *Invisible wounds of war: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: RAND Corporation.
- Verey, A., & Smith, P. K. (2012). Post-combat adjustment: Understanding transition. *Journal of Aggression, Conflict and Peace Research*, 4(4), 226–236.
- Wiens, T. W., & Boss, P. (2006). Maintaining Family Resiliency Before, During, and After Military Separation. In C. A. Castro, A. B. Adler, & T. W. Britt (Eds.), *Military life: The psychology of serving in peace and combat: Vol. 3: The military family* (pp. 13–38). Westport, CT: Praeger Security International.