

**SENATE STANDING COMMITTEE ON FOREIGN AFFAIRS,  
DEFENCE AND TRADE**

**INQUIRY INTO THE MENTAL HEALTH OF AUSTRALIAN  
DEFENCE FORCE (ADF) PERSONNEL WHO HAVE  
RETURNED FROM COMBAT, PEACEKEEPING OR OTHER  
DEPLOYMENT**

**DEPARTMENT OF DEFENCE WRITTEN SUBMISSION  
REGARDING THE INQUIRY TERMS OF REFERENCE**

**JUNE 2015**

## INTRODUCTION

1. On 25 March 2015 the Senate referred the following matter, “[\*The mental health of Australian Defence Force \(ADF\) personnel who have returned from combat, peacekeeping or other deployment.\*](#)” to the Foreign Affairs, Defence and Trade References Committee for inquiry and report by 19 February 2016.

2. This submission reflects the depth and breadth of reforms that have been undertaken in recent years and the range of mental health care services and initiatives that are available to Australian Defence Force (ADF) personnel and their families. Whilst the primary focus in this submission is on serving ADF personnel and their families as this aligns with the Department’s primary responsibility, Defence continues to collaborate with Department of Veterans’ Affairs (DVA) and contributes to the management of broader veterans’ mental health issues. (Throughout the submission links to relevant Defence Internet web sites are provided for reference purposes.)

3. The Australian Government is committed to promoting good mental health for all ADF personnel and their families, and recognises that mental fitness is as important as physical fitness to the capability of the ADF.

4. The majority of ADF personnel will not develop mental health problems or illness during or after their military career. Furthermore, most Defence members who have experienced operational deployments are not likely to develop chronic and lifelong physical and mental illnesses.

5. ADF personnel who do experience mental health problems or mental illness or suicidality, can and do lead meaningful and productive lives within the ADF and seeking help early and engaging in effective treatment can lead to improved outcomes and prevent future problems. Notwithstanding, mental health remains a challenging issue and is a key priority of the ADF senior leadership.

6. Some ADF personnel will be exposed to potentially stressful and traumatic experiences throughout their time in the ADF. For some, the effects of such exposure may not become apparent while they are still in service but only after they have left the ADF and transitioned back into civilian life. Military service may also impact on the families of our personnel as they support their loved ones.

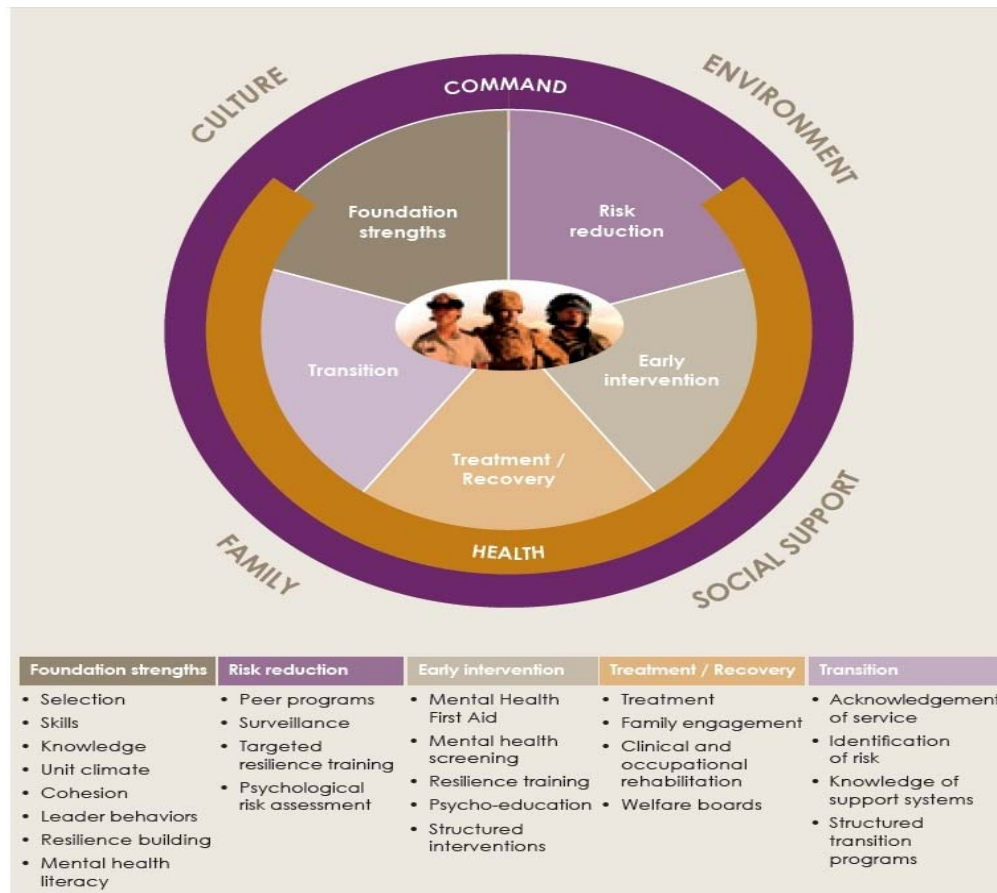
7. We have in place significant initiatives, some in collaboration with DVA, to improve awareness and treatment of mental disorders, including Post-Traumatic Stress Disorder (PTSD).

8. We recognise that exposure to trauma during deployment can increase a person's risk of developing a mental disorder such as PTSD. Data derived from our research show there is a higher rate of PTSD in males in the ADF compared to the general population. The data also highlights that PTSD symptoms increase among those personnel who are more likely to be exposed to traumatic events, whether in Afghanistan, on our border protection operations or humanitarian and disaster relief missions, or indeed, when in garrison or off-duty.

9. We aim to be responsive to the specific needs of the ADF population and their families. This includes assisting them to build and maintain their mental fitness at all stages of their career and as required, to assist them to access effective and timely treatment no matter what the cause or source of their illness or injury. Through treatment and rehabilitation we assist individuals to recover, to continue their service within the ADF or return to a meaningful and productive life in the broader Australian community with the recognition and support they deserve following service to their country.

## DEFENCE APPROACH TO MENTAL HEALTH AND WELLBEING

Due to the unique demands of military service the [ADF Mental Health and Wellbeing Strategy](#) is underpinned by a military occupational mental health and wellbeing approach (see Figure 1).



10. This approach recognises that fundamental to strengthening resilience and enabling recovery in a military environment is a shared responsibility for mental health and wellbeing between command, individual ADF personnel and the health care system.

11. To address mental health issues, as an organisation and amongst our people, our approach cannot only be seen as a health or clinical care response but mental health considerations are increasingly part of our command and leadership training, personnel management and human performance considerations and the way we encourage Defence members to look out for each other. In this way we are promoting the expectation that mental health and suicide prevention is truly everyone's business requiring an organisational response not just an individual one.

12. Although the issue of PTSD and deployments is a very important one, it is not reflective of the full range of mental health issues faced by our population. This message has been consistently delivered to us by our ADF personnel in feedback they have provided in response to our annual ADF Mental Health Day activities.

13. If we are to break down mental health stigma and reduce barriers to care there can be no hierarchy of mental illness- i.e. those mental health conditions caused by operational service versus those from non-operational causes. We are interested in all of our personnel, no matter the source or cause of their mental health problems.

## **Mental Health reform in the ADF**

14. As early as 2002 Defence developed its first ADF Mental Health Strategy and [programs](#) to promote mental health and wellbeing and address suicide awareness and the misuse of alcohol, tobacco and other drugs.

15. The [ADF Mental Health Reform Program](#) was initiated in 2009 in response to the 52 recommendations delivered by Professor David Dunt in his [Review of Mental Health Care in the Australian Defence Force and Transition through Discharge](#).

16. The Australian Defence Force Mental Health and Wellbeing Strategy, released in 2011, and the supporting [Action Plan](#) released in 2012, set priority actions through to 2015 with particular attention to addressing stigma and barriers to care, responding to the mental health impacts of deployments, alcohol misuse and suicide prevention.

17. The plan and consequent reforms and development have been informed by the ADF Mental Health Advisory Group. Set up in 2010, Defence invited a number of external mental health experts, clinicians, policy advisors and researchers including Professor David Dunt to be part of the Mental Health Advisory Group and provide advice and guidance to the ADF Mental Health Reform Program. Since then this group, also including representatives of [Joint Health Command](#), single Services, [Defence Community Organisation](#), [Defence Families Association](#), DVA and the [Veterans and Veterans Families Counselling Service](#), has met seven times.

18. The reform program has provided evidence of the prevalence of mental health disorders in the ADF allowing us to tailor our resilience, awareness, treatment and recovery programs to the changing needs of Defence members and their families.

19. Consultations for development of a new ADF Mental Health and Wellbeing Strategy 2016 – 2020 commenced in March 2015. These consultations are being led by Joint Health Command and will involve engagement with a broad range of stakeholders, both internal and external to Defence.

## **Summary of Developments and Achievements since 2009**

20. Since 2009 Defence has implemented all 52 of the Dunt Review recommendations: invested over \$146 million in mental health services and support (as at 30 March 2015), increased the mental health workforce, improved policy and training for Defence health professionals, increased mental health research and surveillance and strengthened resilience training and prevention strategies.

21. The Defence mental health workforce has been strengthened with a further 91 new positions. As a result the mental health workforce was reinforced with:

- 74 new positions for regional and local service delivery (34 Australian Public Service and 40 contracted providers);
- seven new positions at the ADF Centre for Mental Health (four ADF, two Australian Public Service and one contracted psychiatrist); and
- 10 new positions for policy and program development (one Senior Executive Service Level 1 and nine Australian Public Service).

22. Additionally, under the Medibank Health Solutions contract, Defence has access to another 1,846 mental health service providers (266 psychiatrists and 1,580 psychologists).

23. A summary of other broad developments and achievements since 2009 include:

- world class research giving us a better understanding of resilience needs and strengths of those entering the ADF, the prevalence of mental and physical health conditions amongst our people, the impact of exposure to trauma and deployments and the role of families in rehabilitation;
- enhanced policy to guide ADF personnel, command and health providers in areas of mental health care, suicide prevention and alcohol misuse in the ADF and responding to specific mental health conditions such as PTSD and depression;
- mental health education resources and activities such as the annual ADF Mental Health Day to reduce stigma and barriers to care by increasing awareness of mental health issues and understanding of PTSD, depression, suicide prevention and alcohol misuse and how to seek help as early as possible;
- strengthening our resilience training delivered throughout a Defence member's career, beginning at recruitment, to assist in preparing them to cope better with and meet the unique risks of military service;
- a comprehensive Mental Health Screening Program to identify and provide assistance to individuals who have been exposed to potentially traumatic events through activities such as deployments, Border Protection operations, humanitarian and disaster relief missions or training accidents and a trial to include family members in Post Operational Psychological Screening;
- enhancing our delivery of mental health care and alcohol and other drugs programs through the Garrison primary health care service and implementation of a nationally consistent approach to intake, assessment, counselling services, referral to specialist treatment if required and care coordination for those with complex needs;
- establishing the [ADF Centre for Mental Health](#) to support promotion of evidence-based proactive training of health providers and provision of specialist advice and consultancy to health providers and command;
- establishing the [ADF Alcohol Management Strategy and Plan](#) 2014-17 which sets out a four-year framework for improving alcohol management and reducing the negative impact of alcohol on the health, safety, capability and reputation of the ADF and forms a component of the Defence [Pathway to Change: Evolving Defence Culture](#);
- enhanced rehabilitation programs and clinical treatment options for those with complex physical and mental health needs through [Intensive Rehabilitation Teams](#), psychosocial support services such as ["Mate to Mate" Peer Support](#) and ["Families Stronger Together"](#) training, [Meaningful Engagement Options](#) and research into the role of families in rehabilitation; and
- a [Memorandum of Understanding](#) between Defence and DVA supporting joint and collaborative work in areas such as improved information sharing, research into mental health and rehabilitation, transition services, mental health promotion and education online resources and access to services of the Veterans and Veterans Families Counselling Service.

## **IN RESPONSE TO THE SPECIFIC TERMS OF REFERENCE**

### **A. THE EXTENT AND SIGNIFICANCE OF MENTAL ILL-HEALTH AND PTSD AMONG RETURNED SERVICE PERSONNEL**

24. Defence has undertaken a significant body of research to understand the health and well-being of ADF personnel. This research includes the 2010 [ADF Mental Health Prevalence and Wellbeing Study](#) (released in 2011) and the [Middle East Area of Operations \(MEAO\) Census and Prospective Health Studies](#) (released in 2013).

25. From these studies we know the rate of PTSD and other mental disorders in the ADF and how these rates compare to the Australian community. For example, it is estimated that 22% of the ADF will experience a mental health disorder in a 12 month period and just over half (54.1%) will experience a mental health disorder in their lifetime. This lifetime rate of disorder is significantly higher than the Australian community.

26. We know that deployment is not a necessary precursor to developing PTSD. The results suggest that some members may develop PTSD prior to their first deployment as a result of traumas experienced earlier in their lives. We also know that the greater the number of lifetime trauma exposures, the greater the risk of posttraumatic stress symptoms and that certain groups in the ADF are more likely to be exposed to traumatic events as a result of their role on deployment.

#### **What types of traumas are ADF personnel exposed to?**

27. The 2010 ADF Mental Health Prevalence and Wellbeing Study shows that ADF personnel are subject to the same lifetime exposures as any other Australian, as well as job specific exposures. These exposures can be specific to the military setting or occur in general life. As such they may include combat, life threatening accidents such as motor vehicle accidents, natural disasters, interpersonal violence (including rape and domestic violence) and seeing someone badly injured or killed. Apart from the experience of combat any of these general events can occur in childhood or adulthood, and in a work or non-work related context.

28. Regardless of the type and location of deployment, the most common potentially traumatic event being reported by deployed personnel during Return to Australia Psychological Screening in Annual Mental Health Surveillance Reports have consistently been 'in danger of being injured', followed by 'in danger of being killed' and 'heard of a close friend or co-worker who had been injured/killed/died'. This is different from Navy personnel deployed on OP RESOLUTE, who reported in the Mental Health and Wellbeing Questionnaire that the most common exposure was 'witnessed human degradation/misery on a large scale' followed by 'in danger of being injured'.

29. According to the study, 90% of ADF personnel have experienced at least one potentially traumatic event at some time in their life, compared to 73% of an age and employment matched sample of the Australian community.

#### **How many ADF personnel have PTSD?**

30. Historically the ADF has used a paper based medical records system and without reviewing every record it is not possible to determine how many Defence members were diagnosed with, or received treatment, for any specific condition. Below is a brief summary of data from a number of data sources within Defence.



31. Despite the higher prevalence of exposures to traumatic events in the ADF, most members will not go on to develop PTSD. The 2010 ADF Mental Health Prevalence and Wellbeing Study found that around 8.3% (4,169) of ADF personnel had experienced PTSD in the previous 12 months as a result of life-time trauma in their personal and/or military lives.

32. The study also showed that ADF males report higher rates of PTSD (8.1%) than males in the general community (4.6%). There is no statistical difference in the rate of PTSD between ADF males and females (10.1%), however, trauma histories differ between ADF males and females, with males more likely to report deployment related and accident or other unexpected traumas, whereas females were more likely to report interpersonal traumas.

33. Defence does capture data on members with PTSD who are presented to their single-Service Medical Employment Classification Review Board to have their suitability for ongoing service assessed. Since 2007, data has been collected on those cases referred to the Navy, Army and Air Force Medical Employment Classification Review Board for consideration. Approximately 3,770 members with mental health conditions have been considered by a Medical Employment Classification Review Board. Of these 931 (25%) were diagnosed with PTSD, while 490 (13%) were diagnosed with PTSD and a co-existing mental health condition.

34. For the period July 2013 to June 2014, out of 5,013 rehabilitation referrals, 869 (17.3%) of the referrals to the [ADF Rehabilitation Program](#) were due to a primary diagnosis of a mental health disorder, compared to 3,620 (72.2%) for a physical condition and 524 (10.5%) for medical or other conditions. Of the mental health referrals, 206 (23.7%) had a diagnosis of PTSD. Of those members with a mental health disorder who completed a rehabilitation program, 52% (420) had a successful return to work.

35. Of 60 referrals to the ADF Centre for Mental Health 2nd Opinion Clinic, which is for ADF personnel with chronic, difficult, complex or treatment resistant mental disorders, 13% had a diagnosis of PTSD.

### **What is the impact of deployments, especially multiple deployments?**

36. The 2010 study indicates that ADF personnel who have never deployed are broadly as likely to have PTSD (8.8%) as those who have deployed (8.0%). In addition, recent results from the Middle East Area of Operations Health Studies suggest that the number and length of deployment is not a useful marker of risk for PTSD.

37. However there was a relationship between lifetime trauma exposure and PTSD. The number and type of traumas as well as the role performed on deployment, such as combat or explosive ordnance roles, may assist Defence to identify those most at risk. The findings reinforce the importance of the work Defence is doing in ensuring risk-based intervention and screening to maximise support for those most at risk, not just on deployment.

38. For the period July 2013 to June 2014, 869 ADF personnel were referred to the ADF Rehabilitation Program with a primary diagnosis of a mental health disorder of which, 33.6% were identified as being 'deployment related'. Of those referred with a specific diagnosis of PTSD, (206), 83% (164) were identified as being 'deployment related'.

39. Of the 60 ADF personnel referred to the ADF Centre for Mental Health 2nd Opinion Clinic over the last four years about 29 have had previous deployments.

40. Since 2000, of the 108 ADF personnel suspected or confirmed to have died by suicide, 47 had previously deployed.

41. The 2014 Operation RESOLUTE Mental Health Surveillance Report based on data from the Operation RESOLUTE Mental Health Program, found there was no significant difference between PTSD symptoms reported by Navy personnel deployed to Operations RESOLUTE and SLIPPER. Whilst not necessarily related to multiple deployments, the report identified that the percentage of personnel reporting PTSD symptoms by posting length increased with time, in particular between 'less than 1 year' and 'between 1 to 3 years', with a large rise between the '1 to 3 years' and '4 plus years' groups. Navy personnel posted to Operation RESOLUTE for more than 4 years reported the highest level of psychological distress.

### **What does Defence know about future rates of ADF members seeking treatment for PTSD?**

42. It is difficult to forecast rates accurately because we know from international research of civilian and military populations that less than half of those with mental health disorders, including PTSD, seek help in the initial year after a traumatic event. Research so far has shown that the factors involved in development of a disorder and when ADF personnel may present for treatment are complex, and therefore, we should treat with caution predictions of high rates of disorder. For some individuals it is only through the passage of time that a diagnosable mental health disorder becomes apparent.

43. From the 2010 ADF Mental Health and Wellbeing Prevalence Study, and studies of other military and civilian populations, Defence estimates that at least 8.3% of ADF personnel will have a diagnosable mental health disorder of PTSD at some time during a 12 month period and approximately half of those will report that they received treatment in the previous 12 months. Although the rate of help-seeking may increase, it is predicted that this increase will occur at a gradual pace.

44. Through the [Transition and Wellbeing Research Program](#) Defence and DVA are working together to develop research based evidence to inform both departments on the future rates of ADF personnel and contemporary veterans who may seek treatment for PTSD and other mental health disorders. This research is now underway with data collection initiated on 1 June 2015 and results being available progressively from about June 2016. The program consists of three complementary studies, Mental Health and Wellbeing Transition Study, Impact of Combat Study and Family Wellbeing Study.

45. To encourage ADF personnel to seek support early, Defence provides a range of [mental health education resources and activities](#), which aims to increase awareness of mental health issues, inclusive of an understanding of PTSD, in order to reduce perceived stigma and potential barriers to care.

## **B. IDENTIFICATION AND DISCLOSURE POLICIES OF THE ADF IN RELATION TO MENTAL ILL-HEALTH AND PTSD**

46. Defence has a suite of comprehensive health policies that guide the assessment and treatment of mental health problems and mental disorders. Open accessibility by all Defence members to these policies ensures commanders, health professionals and members are aware of the support available, understand the standardised coordinated approach to treatment, and this is an effective means to decrease the stigma associated with seeking help.

### **Disclosure Policy and Privacy of Health Information**

47. The Health Directive 610 *Privacy of health information of Defence members and Defence candidates* provides the direction on the collection, use and disclosure of health



information in Defence by health professionals, commanders, managers and members. This policy is aligned to the [Australian Privacy Principles](#) as detailed in Schedule 1 of the [Privacy Act 1988](#). In compliance with the Act, Joint Health Command has a [Health Information Privacy Notice](#) available to all Defence members on the Defence intranet, which details how their health information is collected, used and disclosed.

48. In late 2013, Defence conducted a review of health information practices, which subsequently recommended no changes to Defence policies or practices as they are consistent with legislation and the practices of community health practitioners and civilian employers, and reflect the codes of conduct and guidelines applicable to health practitioners on the disclosure of health information to third parties.

49. It is recognised that, just like any member of the Australian community, a Defence member must provide informed consent for their personal health information to be used or disclosed, unless there are exceptional circumstances as defined by the *Australian Privacy Principles*. These may include when use or disclosure is necessary to lessen or prevent a serious threat to a Defence member's life, health or safety, or a serious threat to public health or public safety, including in military workplaces and safety critical areas, such as on deployment.

50. Defence recognises that there have been concerns expressed by family members about what information can be disclosed to them and how disclosing certain health information could have resulted in better mental health outcomes, or in extreme situations prevented a death by suicide. Defence's focus is on ensuring that ADF personnel are afforded appropriate privacy protections while encouraging the member to involve their families and support networks in their mental health safety plan, treatment and recovery by sharing their health information should they wish to do so.

51. In Defence, health information is primarily collected by Defence health practitioners in order to clinically manage and treat a Defence member's health on an ongoing basis. The sharing of health information between all treating health professionals is necessary for the provision of coordinated health care services in particular where a member is receiving mental health care. This can include the member consenting to an external health care provider having complete access to their Defence health records if required.

52. In the context of providing health care in Defence, Defence health professionals are obliged to keep commanders and managers informed of the health status of ADF personnel to enable them to manage the workplace and operational impact of the member's health condition. In this case, unless the member has provided consent, the health information provided is limited to information that enables a member's administrative management to be coordinated with their health support and rehabilitation management plans.

## **Defence Health Policy on Identification and Management of Post-Traumatic Stress Disorder**

53. The Health Directive 264 *Management of Post-Traumatic Stress Disorder and Acute Stress Disorder in the Australian Defence Force for primary care providers* provides clinical practice guidelines for the assessment, treatment and management of ADF personnel experiencing Acute Stress Disorder and PTSD, acutely in a deployed environment and comprehensively in a garrison setting.

54. The guidelines provided are consistent with the 2013 [Australian Guidelines for the Treatment of Acute Stress Disorder and Post-Traumatic Stress Disorder](#) developed by [Phoenix Australia](#) – Centre for Posttraumatic Mental Health and approved by the [National](#)

[Health and Medical Research Council](#). They are also aligned with the [World Health Organisation treatment protocols for mental health disorders](#), and include a standardised screening tool with ADF specific thresholds, and a standardised diagnostic tool based on diagnostic criteria used in the Diagnostic and Statistical Manual of Mental Disorders.

55. The policy requires Defence mental health professionals to assess for co-existing conditions, which are common with Acute Stress Disorder and PTSD presentations. Treatment guidelines emphasise the need for coordinated mental health care and management, especially given the nature of Acute Stress Disorder and PTSD symptoms and likelihood of co-existing conditions. Intervention guidelines include the use of evidence-based treatment approaches, which are trauma focused Cognitive Behavioural Therapy, Cognitive Processing Therapy or Eye Movement Desensitisation and Reprocessing therapy, supported by psychopharmacological therapy as required. The Health Directive supports the return to work, where clinically indicated, of Defence members that have a diagnosis of Acute Stress Disorder or PTSD.

56. Health Directive 264 guides the clinical assessment and treatment of Acute Stress Disorder and PTSD in the ADF environment only. The successful holistic and coordinated management of ADF personnel experiencing Acute Stress Disorder or PTSD includes the application of all relevant policies and programs available to Defence members, and the engagement of command, welfare and health providers as well as the member and their family.

### **C. RECORDKEEPING FOR MENTAL ILL-HEALTH AND PTSD, INCLUDING HOSPITALISATIONS AND DEATHS**

57. Health related record keeping is managed in accordance with the Defence Records Management Policy and the relevant legislation. Defence is currently redeveloping health records management policy to provide a single policy for all ADF personnel that receive health services from Defence.

#### **Defence e-Health System (Defence e-Health System)**

58. The implementation of the Defence e-Health System has resulted in the minimisation of paper records with the majority of Defence members receiving primary health care treatment through a [Garrison Health Organisation](#) health centre or clinic. All mental health and psychology records prior to the implementation of the System will remain available. As the legacy systems are decommissioned they are being reviewed and the pertinent records will be transferred to Objective (the approved restricted Defence electronic records management system) as part of the decommissioning process.

59. Mental health professionals working in Garrison health centres, and where appropriate single-Service psychology sections, use the Defence e-Health System to record their consultations with members, via the suite of Mental Health and Psychology Templates which are part of Defence e-Health System. Additional clinical protocols for mental health and psychology sessions are being developed in order to facilitate the standardisation of recordkeeping, improve the efficiency of services and provide a clinical governance framework nested in the System.

60. The data analysis and reporting functions of Defence e-Health System that support the clinical governance framework will in the future enable Defence to target reporting for specific mental health presentations and disorders. This reporting is expected to provide Defence with the health intelligence that can be used to inform policies and programs, and to ensure treatment protocols are appropriately applied to specific disorders. Access to health

reports and requests for ad-hoc reports is managed through Joint Health Command to ensure appropriate use and protection of the health information contained within the report.

61. The internet portal for members to access their e-Health record is due for implementation in the second half of 2015. Defence members will be able to view a summary of their health record, recent and scheduled appointments and complete health questionnaires as preparation for a mental health consultation. Routine mental health questionnaires and screening tools are some of the health questionnaires that will be accessible to members online, with mechanisms incorporated to advise mental health professionals when the results of a questionnaire need to be responded to urgently.

62. Records raised by welfare agencies external to Defence health, such as the Defence Community Organisation, often pertain to services that are provided to individuals in a member's family, and therefore are not documented in the Defence member's health record under the *Australian Privacy Principles*. The Defence Community Organisation has robust records management procedures which require staff to document client sessions, case notes, risk assessments and details of referrals on a discrete Defence Community Organisation case management system. Although there is no formal requirement for Defence Chaplains to maintain client notes, where the chaplaincy support being provided forms part of the coordinated care approach to a Defence member, Chaplains would normally make diary entries to ensure that required follow up was occurring.

### **Hospital Admissions and External referrals**

63. For external mental health referrals to psychiatry, psychology or via the Agreement for Services with the Veterans and Veterans Families Counselling Service, an external referral request is raised in Defence e-Health System and on-forwarded to the relevant external provider. The Defence e-Health System allows for the timely monitoring of external mental health provider reports by the local Mental Health and Psychology Section, and these reports are reviewed at the regular multidisciplinary Case Review meetings to ensure that treatment is meeting the needs of the member, and that the member remains engaged with the external provider. The external reports are then electronically appended to the member's health record via Defence e-Health System in order to provide a continuous view of the member's mental health care.

64. Similar to the Australian community, the primary Garrison health care services are provided via a General Practitioner model of care. Therefore, ADF personnel requiring admission to external treatment facilities as an inpatient access these services either as an emergency admission through an Accident and Emergency tertiary facility, or by Defence Medical Officer referral to a psychiatrist with admission rights to a particular facility for both acute or planned admission to that facility or in-patient treatment program. The referral remains in the member's individual e-health record and a Notification of a Casualty (NOTICAS) and a Medical Casualty (MEDICAS) are raised, which are notifications that allow for command, health and welfare agencies to ensure that the member's occupational, health and domestic needs are met, and the member's family is supported during the admission.

65. Any Defence member admitted to an external treatment facility for mental health in-patient treatment is regularly followed up by the local Mental Health and Psychology Section. The Health Services Contract with Medibank Health Solutions ensures that the referring or local garrison health facilities are advised when a member is discharged from an external inpatient facility. In accordance with best practice, a discharge summary report is provided to the treating garrison health facility once in-patient treatment is complete. This report is

uploaded into Defence e-Health System and any further treatment or management requirement is discussed at a multidisciplinary case review meeting.

## **Recordkeeping for Defence Fatalities**

66. Upon triggering by a Notifiable Fatal Casualty (FATALCAS), which is a notification that provides for coordinated command, health and welfare management of the death of a serving member, Defence has developed an archiving process for the health records following the death of a Defence member. This involves the movement of the deceased member's health record from Defence e-Health System (the active health record management system) to Objective (the approved restricted Defence electronic record management system for archival purposes). Defence health care professionals can continue to access the health record as required, and members' families can request access using normal Defence record access request processes. Both Defence e-Health System and Objective have flags to identify that the member's record is in Objective. This ensures continued retention and access for the health record of a Defence member as required by the [\*Archives Act 1983\*](#).

## **D. MENTAL HEALTH EVALUATION AND COUNSELLING SERVICES AVAILABLE TO RETURNED SERVICE PERSONNEL**

### **Mental Health, Psychology and Rehabilitation Services in Defence**

67. Mental health, psychology and rehabilitation services are provided in Defence as an integral component of the overall Defence primary health care system which ensures that a multidisciplinary and holistic approach to mental health care is achieved. Early identification and access to treatment and rehabilitation for mental health issues are key priorities for Defence.

68. The delivery of mental health and psychology services is a multi-tiered responsibility with Garrison Health Operations providing the strategic planning and coordination of the regional health services, the ADF Centre for Mental Health providing a national operational level for workforce training and the management of programs, the Regional Mental Health Teams providing the regional operational level by delivering clinical supervision to service providers and coordinating services for the Joint Health Units and the Mental Health and Psychology Sections at the tactical level providing local health services to ADF personnel.

69. The services are delivered by a wide range of health professionals including uniformed medical officers and mental health professionals from all three Services, Australian Public Service mental health professionals, contracted medical practitioners, mental health professionals and specialists, Reserve mental health professionals who provide clinical specialist care and civilian mental health professionals and specialists.

70. The mental health, psychology and rehabilitation services in Joint Health Command are increasingly provided in coordination with the Defence welfare support agencies, including the Defence Community Organisation and Defence Chaplaincy. The close working relationship between health and welfare is vital to the effective delivery of holistic, member centric, family sensitive mental health services. Accordingly, these agencies continue to improve on the provision of coordinated services.

71. **Recent service delivery improvements.** Defence is committed to continuous improvement to health services, and, supported by Defence e-Health System, has recently successfully implemented two key projects in the mental health, psychology and rehabilitation area.

72. The Case Management Project was established to implement a standardised and nationally consistent approach to patient management and oversight for cases that are complex and/or where high level coordination and situational awareness is required. The key element of the model is the Health Care Coordination Forum, which provides oversight and coordination of case management by enhancing the collaboration between health care providers, Command and members and their families.

73. The Mental Health Integration Project ensures the key principles of the Mental Health and Psychology Service Delivery Model are implemented in accordance with best practice and with national consistency in all Joint Health Command health facilities. The objective is to improve access into the health care system, provide assessments in a timely manner, better match client need to the appropriate level of care and ensure that the individual's progress is regularly monitored and reviewed.

## **Mental Health, Psychology and Rehabilitation Programs**

74. The delivery of mental health, psychology and rehabilitation services is enhanced by a number of specific programs and initiatives. These programs are described below.

75. **General awareness and promotion resources and activities.** To aid in the mental health literacy and awareness for ADF members and their families, a range of promotion resources and activities are provided. These include [topical fact sheets](#), Internet access to [mental health information](#) via the [ADF Health and Wellbeing portal](#), provision of Defence help lines ([All-Hours Support Line](#), ['1800 IM SICK'](#) and [Defence Family Helpline](#)) and, in partnership with DVA, a number of [mobile applications](#). Aligned with annual international and national mental health awareness initiatives in October, the ADF Mental Health Day is a significant opportunity to further the understanding of mental health issues in Defence.

76. **Rehabilitation specific programs.** Enhancing the delivery of coordinated recovery focussed mental health care is a range of rehabilitation specific programs mutually provided by Joint Health Command and the single-Services. The ADF Rehabilitation Program aims to return ADF personnel who are injured or ill to work in Defence or to successfully medically transition to the civilian environment. This program is supported by guidebooks for commanders, members and their families, and is reinforced by the [Simpson Assistance Program](#) and the single-Services [Support to Wounded, Injured or Ill Program](#).

77. The Simpson Assistance Program is a series of initiatives that enhance the existing rehabilitation efforts by developing tailored recovery programs to support the individual needs of ADF personnel and their families. Initiatives which have been developed and piloted include the Intensive Rehabilitation Teams, 'Mate-to-Mate' Peer Visitor program, Meaningful Engagement Options and the Living with Disability 'Families Stronger Together' residential workshop. These new programs have been evaluated and are being integrated in the suite of rehabilitation programs.

78. The Support to Wounded, Injured or Ill Program is a joint Defence and DVA program delivered under a Memorandum of Understanding that aims to facilitate the effective management of ADF members engaged in rehabilitation through a framework that considers the needs of the member and their family, and delivered by the coordination of command and supporting health and welfare agencies to ensure that every member returned to the workplace contributes to ongoing capability. This program is supported by the single-Services and includes the introduction of [Soldier Recovery Centres](#) and [Member Support Coordinators](#) to facilitate the coordination of support services and engagement in meaningful activities for ADF personnel in a positive recovery focused environment.



79. One of the initiatives in the single-Services is the use of Individual Welfare Boards (IWB) or Case Conferences. These are overseen by command and include representation from health and welfare services, other agencies such as DVA when required, as well as the member and where appropriate, their partner or other significant family member or carer. The aim of IWB or Case Conferences is to track a Defence member's rehabilitation and recovery progress, coordinate support and identify any problems in the provision of care and return to work or transition, if required.

80. Another new initiative is the ADF Arts for Recovery, Resilience, Teamwork and Skills Program, which followed on from the success of the [ADF Theatre Project – 'The Long Way Home'](#), and is a unique creative arts program utilising music, drama, creative writing and visual arts to aid in recovery.

81. The importance of rehabilitation in Defence is demonstrated by the holding of Senior Leadership activities including the Chief of Defence Force Rehabilitation and Recovery Workshops and the Chief of Army Wounded, Injured and Ill Digger Forum, both of which seek to further the effectiveness of Defence's processes across the rehabilitation-transition continuum. In addition, the Chief of Army hosts Army-Industry Partnership Initiative meetings that aim to identify industry based training, development and placement/employment opportunities for rehabilitating members.

82. **Mental health and psychology programs and training.** The services delivered to individual members and their families are enhanced by specific mental health and psychology programs which include ones focussed on drug use (ADF Alcohol, Tobacco and Other Drugs Program) and suicide prevention (ADF Suicide Prevention Program). Both of these programs are comprehensive in their scope via the delivery of general awareness training, specific training for mental health professionals, provision of assessment and treatment options and assist in the publication of Defence policy in order to standardise the management of these issues.

83. Defence enhances the delivery of mental health, psychology and rehabilitation services by provision of training to ADF personnel and the Defence mental health workforce.

84. Training available to ADF personnel includes the Keep Your Mates Safe - Peer Support Network, which is intended to address stigma, increase awareness of support services and provide practical mental health first aid skills, and the BattleSMART (Self Management and Resilience Training), which is a preventive program designed to enhance an individual's ability to cope effectively with increased stress and adverse or potentially traumatic events in their lives.

85. In order to ensure that the mental health care provided in Defence is aligned with community best practice and suits the ADF environment the Defence Mental Health Workforce Clinical Skilling Framework has been developed. This ensures that all Defence mental health professionals are trained, credentialed, supervised and supported to deliver services to ADF members, including upskilling in PTSD, Suicide and Alcohol, Tobacco and Other Drug assessment and treatment, acute management of mental health presentation in the deployed environment and in the provision of family sensitive practice.

## **Operational Mental Health and Psychology Support**

86. Defence recognises that war, warlike, peacekeeping and peacemaking operations may expose ADF personnel to significant risk factors for the development of long-term mental health problems and mental disorders. Defence therefore provides operationally focused mental health promotion, prevention and early treatment services for all such



deployed forces. The aim of the ADF Operational Mental Health Support is to assist ADF personnel to deploy, perform their operational duties effectively and then return to work and private lives with minimum disruption.

87. In addition to the services and programs available to all ADF personnel, and with respect to members who have deployed, operational mental health services are best understood as happening in three phases, as described below.

88. **Pre-deployment phase.** All deploying ADF personnel receive a BattleSMART mental health brief that is designed to enhance their ability to operate effectively in the deployment environment and is tailored to meet the specific demands of the deployment. The BattleSMART pre-deployment training is delivered in conjunction with a comprehensive pre-deployment training package.

89. **Deployment phase.** For deployed members that are exposed to potentially traumatic events a [Critical Incident Mental Health Support](#) response is provided, consisting of a group psycho-education brief on expected trauma reactions, coping skills and methods on seeking support, followed by targeted individual screening questionnaire and screening interview. This aims to identify members that require immediate intervention or scheduled follow up and facilitate a return to pre-exposure functioning. Deployed high risk groups, those whose operational role may routinely expose them to intense operational stressors, critical incidents, and/or potentially traumatic events, such as military police, explosive ordnance disposal personnel and health personnel are provided a Special Psychological Screen approximately mid-way through the deployment regardless of their actual exposure to potentially traumatic events.

90. This phase concludes with the Return to Australia Psychological Screen preferably conducted during the week prior to a member leaving the operational theatre. This comprises a BattleSMART re-adjustment focused group briefing and an individual screening questionnaire and screening interview. This aims at identifying members that may benefit from an immediate referral or early follow-up due to the deployment's impact upon their current level of psychological functioning and/or members who may potentially experience adjustment difficulties upon return to Australia. The BattleSMART re-adjustment brief is reinforced and local mental health and welfare support contacts provided during the first week back in Australia.

91. **Post-deployment phase.** In this phase, a Post-Operational Psychological Screen is completed between three to six months following the Return to Australia Psychological Screen. The Post-Operational Psychological Screen comprises a screening questionnaire and interview and aims to identify ADF personnel who are having reintegration difficulties with family, civilian community and routine military duties following their deployment, and facilitates the member in accessing the appropriate support.

92. **Deployment specific support.** Dependent on the requirements of the operation the mental health services provided may not suit the phased approach and require a level of adaptation. For example, for Operation RESOLUTE, a tailored program of mental health support is provided to assigned Navy crews and Transit Security Element personnel. This program commenced in June 2011 and comprises a biennial group SMART resilience brief, annual Mental Health and Wellbeing Questionnaire and a screening interview with a Navy psychologist. The aim of the program is to provide psycho-education, surveillance and early identification and referral of personnel who require follow-up mental health support.

## **F. THE SUPPORT AVAILABLE FOR PARTNERS, CARERS AND FAMILIES OF RETURNED SERVICE PERSONNEL WHO EXPERIENCE MENTAL ILL-HEALTH AND PTSD**

93. Defence continues to develop a family sensitive practice approach to the delivery of the mental health, psychology and rehabilitation services delivered to ADF personnel. As part of the commitment, Defence has a range of preventive and responsive measures to assist the families of ADF personnel in managing the demands of military life.

94. The ADF displays this commitment by providing services directly to families as well as up skilling the mental health workforce. For example, specific family sensitive practice training via the Bourverie Centre at La Trobe University was provided to Defence mental health professionals involved in the provision of a Family Inclusive Post Operational Psychological Screening trial. The ADF Centre for Mental Health 2nd Opinion Clinic routinely invites appropriate family members to participate in the assessment of those members referred. The [ADF Family Health Program](#) provides financial support to Defence families when accessing community health care (100% coverage for General Practice treatments and a capped amount for specialist care). In addition, Defence families have access to the range of mental health promotion resources and service guides for the available rehabilitation programs via the Internet ADF Health and Wellbeing portal and are encouraged to access the DVA '[At Ease](#)' Internet portal as well. Defence family members can access two telephone help lines in order to seek specific support and advice (ADF All-Hours Support Line and Defence Family Helpline).

95. ADF personnel and their families are encouraged to access the Veterans and Veterans Families Counselling Service either through self-referral, if eligible, or for the Defence member, from a Defence initiated referral via the Agreement for Services. The provision of services to Defence members and their families by the Veterans and Veterans Families Counselling Service is a significant force-multiplier for the mental health and psychology services, in particular in the provision of family inclusive practice. DVA has supported the use of the Veterans and Veterans Families Counselling Service by Defence and has expanded service locations to facilitate improved access to mental health care. For the period July 2013 to June 2014, a total of 3726 serving Defence members accessed the Veterans and Veterans Families Counselling Service support. Of these 24.2% (911) were referred by Defence with the remainder self-referring.

96. The Defence Community Organisation provides a comprehensive range of support options for Defence families and members that can be accessed directly via a regional Defence Community Organisation office or the Defence Family Helpline.

97. Defence Community Organisation regionally based social workers and Defence Family Helpline staff are able to provide brief interventions to families which can include assisting the family member or partner with their own support system, discussing strategies to enhance help seeking and supporting treatment, options to access treatment, exploring strategies to deal with volatility and anger and also withdrawal and anticipating and managing triggers.

98. In addition to the regular '[Defence Family Matters](#)' publication, the Defence Community Organisation also provides resources through its publically available [Internet website](#) including information on suicide prevention, encouraging a loved one to seek help, support to families of wounded, injured or ill ADF personnel, resources for ADF personnel experiencing trauma and preparing your family for when a deployed partner comes home. To further accessibility of services the Defence Community Organisation is also partnered with

Defence and DVA on the development of a new online resilience program designed for veterans, members and families.

99. Defence families can also access the Defence Community Organisation's range of family support programs, for example the [FamilySMART Resilience program](#), which helps families to develop their psychological resilience and improve family / social connectedness. In addition the Defence Community Organisation workers deliver briefs to families about a broad range of family support options and make use of functions and activities to engage with families. They frequently participate in [Individual Welfare Boards](#) for Defence members where they are able to provide a psychosocial perspective.

100. For support to families with deployed members the Defence Community Organisation provide support calls to partners or parents, which provide the opportunity for family members to raise any concerns and have them referred to the appropriate responder. During periods of absence from home the Defence Community Organisation supports Command to meet its Defence member and family welfare responsibilities. This requirement is primarily met through the provision of support services, the [Emergency Support for Families Scheme](#) and psycho-educational programs such as [FamilySMART Reintegration](#).

101. Defence also supports members and their families through their separation from the ADF. The [ADF Transition Centres](#) ensure that members and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning.

102. Additionally Defence encourages the use of the DVA "[On Base Advisory Services](#)" provided under the Memorandum of Understanding and available on over 44 Defence bases across Australia. Through the On Base Advisory Services, ADF personnel can seek early advice and information about DVA support services and are encouraged to lodge compensation claims prior to transition to civilian life.

## **H. THE EFFECTIVENESS OF THE MEMORANDUM OF UNDERSTANDING BETWEEN THE ADF AND DVA FOR THE COOPERATIVE DELIVERY OF CARE AND SUPPORT TO ELIGIBLE PERSONS**

103. In February 2013, Defence and DVA signed the Memorandum of Understanding for the Cooperative Delivery of Care and Support to Eligible Persons. The Memorandum of Understanding reflects recognition within both Departments that responsibility for the delivery of the necessary care and support is shared and can be best delivered under a lasting, cooperative framework that covers joint responsibilities across workplace health and safety, health care, rehabilitation, compensation and transition from the ADF into civilian life and thereafter.

104. Under the Memorandum of Understanding, Defence and DVA maintain a strong, coordinated and effective relationship, which supports the oversight of the normal interaction between the two departments, allows the development of joint initiatives and ensures that each department is aware of, and can contribute to, key departmental initiatives being progressed independently.

105. Complementing the [Military Rehabilitation and Compensation Commission](#) and sub-committee, joint governance arrangements that are supported by the Memorandum of Understanding include the Annual [Defence/DVA Executive Committee](#), which is the strategic level body, and the Quarterly [Defence/DVA Links Steering Committee](#), which is the operational level body and oversees the implementation of joint initiatives and services, and

monitors the operation of the Support Continuum, the collective term within the Memorandum of Understanding for the systems that deliver care and support. The monthly Defence/DVA Mental Health Working Group provides a tactical level body to discuss joint and independent programs, research and services.

106. An important area of work supported by the Memorandum of Understanding is the Joint Research Committee which mutually supports the Defence and DVA mental health research projects conducted, either jointly or independently. Projects achieved to date under this joint agenda include the mutual recognition of DVA Human Research Ethics Committee decisions by Defence, the development of the Military and Veteran Research Study Roll and ongoing collaboration on research projects such as the [Transition and Wellbeing Research Programme](#) and a Long Term Study into the effects of rehabilitation arrangements within the ADF and DVA.

107. Other outcomes supported through the Memorandum of Understanding include:

- injured or wounded Defence members are encouraged and supported to submit claims for compensation to the Department of Veterans' Affairs through one of over 44 On-Base Advisory Services as early as possible while still serving;
- improvements in information sharing between Defence and DVA including notification of certain events impacting ADF members;
- an Agreement for Services enabling referral by Defence of ADF personnel to the Veterans and Veterans Families Counselling Service (as a Service Provider) independent of eligibility under the Veterans Entitlement Act or the Military Rehabilitation and Compensation Act, on a fee for service basis; and
- Defence working with DVA to inform and support the development and release of a series of web based and mobile applications to promote better awareness, self-management and access to care for current serving and ex-Defence members and their families with concerns about PTSD, alcohol misuse, suicide prevention and resilience.

108. The monitoring and evaluation of the Agreement for Services is conducted by the quarterly Agreement for Services Steering Committee attended by senior Defence and Veterans and Veterans Families Counselling Service leadership. Defence has a strong relationship with Veterans and Veterans Families Counselling Service Centres which is enhanced by Defence involvement in Veterans and Veterans Families Counselling Service Regional Consultative Forums and nationally, by the Veterans and Veterans Families Counselling Service National Advisory Committee.

## **I. THE EFFECTIVENESS OF TRAINING AND EDUCATION OFFERINGS TO RETURNED SERVICE PERSONNEL UPON THEIR DISCHARGE FROM THE ADF**

### **Transition Services**

109. In recent years Defence has improved the level of coordination and integration across welfare, rehabilitation, compensation and [transition programs](#) to improve outcomes for ADF members and their families. Through Joint Health Command working closely with the three Services, the Defence Community Organisation and DVA the goal is to achieve a more seamless transition for a member.

110. Joint Health Command has developed the LifeSMART presentation which aims to increase members' individual psychological resilience and develop awareness of better ways of coping with the challenges of transition to civilian life. This presentation is delivered as part of a two day ADF Transition Seminar that aims to ensure members and their families are well informed and encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning. Regional ADF Transition Centres provide the administrative management and support, where members are required to finalise their arrangements well before their date of separation from the ADF. The [ADF Transition Handbook](#) is a quick guide to transition information and support and is available on the internet.

111. Services provided by the Directorate of National Programs in the Defence Community Organisation ensure that ADF personnel and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning, including the Veterans and Veterans Families Counselling Service Stepping Out Program, which is available prior to separation although attendance is also supported by DVA up to 12 months post separation.

112. Defence is also focussing efforts to ensure that ADF personnel are provided with pathways to civilian employment. The Career Transition Assistance Scheme assists ADF personnel with vocationally-oriented education and training; career coaching, including identifying transferrable skills and interview techniques; coaching on resume writing; and financial coaching. Complementing the scheme, Army, with stakeholders from Air Force, Navy, DVA, Defence industries, recruitment consultants and ex-service organisations, has introduced the Rehabilitation through Employment Initiative that aims to provide pathways to employment for medically separating members.

## **Separation Health Care**

113. ADF personnel undergo a comprehensive Separation Health Examination prior to separation which identifies all physical and mental health issues and ongoing treatment requirements, links them to civilian providers if applicable, completes paperwork for ComSuper (for medical discharges), assists with DVA compensation claim submissions and provides them with a medical summary and supporting documentation to take to their new civilian health care provider.

114. To support DVA's 2014 implementation of a post-discharge General Practitioner Health Assessment for former ADF personnel, Joint Health Command has reinforced the requirements of separation health examinations and emphasised the need to provide a clinical summary for the civilian General Practitioner. Defence's Separation Health Examination aligns closely with the DVA assessment to facilitate a smooth transition to the civilian health care sector for ADF personnel and provides baseline health information for civilian health providers.

115. Defence is committed to providing flexible support for those members who need to separate at short notice for medical or compassionate reasons. Separating members are provided with effective and appropriate rehabilitation support. The Rehabilitation Consultant liaises with all key stakeholders, including the treating Defence Medical Officer, DVA, the Defence Community Organisation and ADF Transition Centre to ensure all required ongoing services are in place, including medical assistance and vocational rehabilitation, before their transition to civilian life.