



RESEARCH REPORT 16/2014: OP RESOLUTE RISK INDICATED MENTAL HEALTH AND WELLBEING - SURVEILLANCE REPORT (JUN 13 - SEP 14)

DECEMBER 2014

DIRECTORATE OF OCCUPATIONAL PSYCHOLOGY AND HEALTH ANALYSIS
JOINT HEALTH COMMAND



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INTRODUCTION

1. Surveillance of mental health and wellbeing is one aspect of an overall mental health support program focussed on Navy crews assigned to Operation (OP) RESOLUTE. In 2010, Fleet Command reported a relative increase in the incidence of mental health issues among Mine Warfare, Clearance Diver, Hydrographic Survey, Meteorological and Patrol Force (MHPFOR) personnel¹. Following a review of extant mental health support arrangements, and in response to the unique stressors associated with OP RESOLUTE (hereafter RESOLUTE), a program of mental health support for MHPFOR crews assigned to RESOLUTE was jointly developed by Navy Psychology and Joint Health Command (JHC). The program was aligned with current operational mental health screening and support procedures provided for other (HQJOC specified) ADF operations.
2. A trial of the RESOLUTE Mental Health program commenced in Jun 11, with the program fully implemented in Aug 13. The program is coordinated and delivered by Navy Psychology personnel, and comprises a biennial group-delivered *Resilience Brief* and an annual *Mental Health and Wellbeing Questionnaire* (MHWQ)².
3. In Jun 13, the RESOLUTE Mental Health program was extended, on a trial basis, to Major Fleet Unit (MFU) crews assigned to RESOLUTE for short-duration rotations. MFU crews assigned to RESOLUTE receive the *Resilience Brief* prior to the deployment; with a currency of two years. During the return passage from RESOLUTE, MFU crews are administered a Risk Indicated MHWQ (RI-MHWQ).
4. As with the full version of the MHWQ, the Risk Indicated (RI) version includes standardised screens from the Return to Australia Psychological Screen (RtAPS) and Post-Operational Psychological Screen (POPS), in addition to discrete mental health and wellbeing items. While tailored to the RESOLUTE context, the standardised screens in both the RI and the full versions of the MHWQ allow for comparison and benchmarking with other identifiable³ operational screens (e.g., RtAPS). Unlike the full version of the MHWQ, the Risk Indicated version does not contain questions regarding occupational concerns or career intentions (due to the shorter duration of the deployment).
5. Following administration of the RI-MHWQ, members who score above a clinical threshold are referred for a follow-up screening interview with a psychologist. The urgency of the referral is aligned to the clinical threshold reached. However, regardless of screening instrument scores, any member of an MFU crew may elect (within the RI-MHWQ) to receive a follow-up screening interview with a psychologist. If an interviewed member is identified as experiencing mental health symptoms, or requiring further support, they are referred to the supporting JHC Health Centre for more detailed assessment and ongoing treatment, if required. In the event of a Critical Incident during deployment, a Critical Incident Mental Health Support (CIMHS) response can be activated by Command.
6. The RI-MHWQ outcomes for personnel assigned to MFU crews will be reported in this Research Report. It should be noted that the screening program measures *symptoms* associated with

¹ FMO Minute FLEET/S3781762 of 10 Dec 10, *Request assistance in implementation of Navy Mental Health Support to MHPFOR Units assigned to Op RESOLUTE*; MHP&R Minute OUT/2011/R8587536 of 31 Mar 11, *Implementation of Mental Health Support to Op RESOLUTE*.

² The Resilience brief and mental health screening requirement is part of the RESOLUTE Health Support Order.

³ Research has demonstrated that scores on identifiable mental health screens (e.g. RtAPS and POPS) tend to be lower when compared to unidentifiable screens (e.g. Mental Health Prevalence and Wellbeing Study). Therefore, the administration method (identifiable versus unidentifiable) is an important consideration when comparing and benchmarking mental health outcomes.

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psychological distress, posttraumatic stress and alcohol usage; it *does not* determine diagnostic rates of mental health disorders, such as Post Traumatic Stress Disorder or Depression. The program was designed to identify members who may be experiencing certain mental health issues (symptoms) at a particular point in time, and enable referral for early intervention and treatment.

7. The current report presents the mental health outcomes and deployment perceptions of screened MFU crews assigned to RESOLUTE, based on RI-MHWQs administered from Jun 13 to Sep 14. A detailed analysis of the full version of the MHWQ administered to Navy crews in 2013 and 2014 (to Jul 14) was reported in a separate Research Report⁴. Where appropriate, comparisons are made in the current report between personnel on MFU crews (Jun 13 – Sep 14) and personnel on MHPFOR crews (Jan – Dec 13 and Jan – Jul 14).

Method

8. The mental health screens in the RI-MHWQ include the Kessler 10 (K10, assessing psychological distress), the Posttraumatic Stress Disorder Checklist - Civilian (PCL-C, assessing posttraumatic stress symptoms), the Alcohol Use Disorder Identification Test (AUDIT, assessing alcohol usage), and the Traumatic Stress Exposure Scale - Revised (TSES-R, assessing traumatic events exposure). For more information about these measures refer to Annex A.

9. The RI-MHWQ is administered to MFU crews assigned to RESOLUTE, with the point of delivery of the screening measure being on the return passage from the deployment. At the time of reporting, the Directorate of Occupational Psychology and Health Analysis (DOPHA) had access to data from 793 completed RI-MHWQs, collected between Jun 13 and Sep 14 inclusive. The data included Navy personnel predominantly from ANZAC Class Frigates.

10. As previously highlighted, mental health outcome results for Navy crews assigned to RESOLUTE who completed full screens (MHWQs) between Jun 11 and Jul 14 have been reported separately. Data from MHPFOR crews (Jan - Dec 13 and Jan - Jul 14) will be reported as a point of comparison with the MFU crews.

11. All 'overall' percentages provided in this report relate to the 793 MFU personnel screened between Jun 13 and Sep 14, and only cases where personnel provided valid answers to the full mental health instrument (i.e. the K10, PCL-C or AUDIT) are included in the analyses. No members were excluded from the analyses due to incomplete data. Where possible, tests of statistical significance (chi-square tests for independence) are also used to ascertain the statistical significance of any differences between groups⁵.

RESULTS AND DISCUSSION

Overall

12. Table 1 presents the total number of MFU and MHPFOR personnel assigned to RESOLUTE who completed either a MHWQ or RI-MHWQ for the period of Jun 11 - Jul 14⁶ and Jun 13 - Sep 14 respectively. It should be noted that (with the exception of referral rates) for the remainder of this report, and for comparison purposes, only those who completed a full version of the MHWQ in

⁴ DOPHA Research Report 14/2014, *OP RESOLUTE Mental Health and Wellbeing Questionnaire: Surveillance Report for Jun 11 – Jul 14*, of Sep 14.

⁵ Note that the statistical significance is dependant upon the size of the sample included in the analysis, and might not indicate a difference of practical significance.

⁶ The MHWQ is administered to both MHPFOR crews and Transit Security Element (TSE) personnel assigned to RESOLUTE. The total number of MHWQ administered to MHPFOR crews and TSE personnel between Jun 11 to Jul 14 is 1499. This report only uses the MHPFOR MHWQ data (N = 1118); as the reference point.

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the period of *either* Jan - Dec 13 *or* Jan - Jul 14 will be used, being 426 and 357 MHPFOR personnel respectively.

Table 1: Total number of personnel screened by RESOLUTE group and screening period.

Group	Total (N)
MFU (RI-MHWQ):	
Jun 13 – Sep 14	793
MHPFOR (MHWQ):	
Jun 11 – Jul 14	1118
<i>Jan – Dec 13</i>	<i>426</i>
<i>Jan – Jul 14</i>	<i>357</i>

13. A crew member is referred for a follow-up mental health assessment with a Mental Health Professional on the basis of either their MHWQ or RI-MHWQ clinical screen scores *and* a screening interview with a psychologist. Table 2 presents the total number of referrals by deployed group (MFU or MHPFOR crew) and referral timeframe.

Table 2: Total number of referrals by RESOLUTE group and timeframe.

Group	N	High (within 72 hours) <i>n (%)</i>	High (within 14 days) <i>n (%)</i>	Medium (within 3 months) <i>n (%)</i>	Total referred <i>n (%)</i>
MFU (RI-MHWQ)	793	- (-)	8 (1.0)	28 (3.5)	36 (4.5)
MHPFOR (MHWQ)	1118	9 (0.8)	17 (1.5)	37 (3.3)	63 (5.6)

Notes:

1. (-) indicates a value of 0.0.

14. Compared to MHPFOR personnel (5.6%), the proportion of follow-up referrals for MFU personnel was slightly lower at 4.5%. No member assigned to a MFU crew required an urgent referral (within 72 hours) and relatively equal proportions in each deployed group required a referred within either two weeks or a three month timeframe.

15. While members completing the MHWQ will always complete a screening interview with a Psychologist, for the RI-MHWQ, members will only receive a screening interview if they:

- a. scored above a clinical threshold;
- b. indicate they would like to see a psychologists (in the screen); or
- c. identified as requiring a screening interview by Command/Health provider.

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After completing the RI-MHWQ, a total of 17.9% ($n = 142$) of screened MFU personnel received a follow-up screening interview. Of these members, 9.2% ($n = 13$) requested the interview themselves or were recommended to have an interview by Command/Health provider.

16. The proportion of screening interviews conducted following the RI-MHWQ administration (17.9%) is likely to be inflated. For one MFU crew in 2013 a lower clinical score threshold on the RI-MHWQ was inadvertently applied when scheduling follow-up screening interviews. This resulted in potentially over-screening crew members based on their RI-MHWQ screen scores. If the clinical score thresholds on the RI-MHWQ which (at a minimum) required a follow-up screening interview are applied to the data, the actual screening interview rate would be 13.5% ($n = 105$).

17. Of those who received a screening interview, just over a quarter (25.4%, $n = 36$) were then referred on for further assessment with a Mental Health Professional. It should be noted that only six of these referrals were reported as being deployment related.

Overall Mental Health outcomes

18. Table 3 below presents the percentages of screened MFU personnel deployed on RESOLUTE who, at the time of the screen, indicated they were either at risk of psychological distress, posttraumatic stress symptoms, and/or risky drinking behaviour compared to equivalent results for MHPFOR personnel across two periods.

Table 3: Mental health outcomes for MFU compared to MHPFOR personnel on RESOLUTE.

		% Psychological distress			% Posttraumatic stress symptoms ⁷				% Risky drinking behaviour ⁸			
N		Mod. (15-19)	High (≥ 20)	\bar{x} (SD)	Med. (30-39)	High (40-49)	Very high (≥ 50)	\bar{x} (SD)	Zone II (8-15)	Zone III (16-19)	Zone IV (≥ 20)	\bar{x} (SD)
MFU												
Jun 13 - Sep 14	793	19.2	11.1	13.9 (4.7)	4.4	1.1	0.1	20.0 (4.7)	13.4	0.3 ⁹	0.4 ¹⁰	4.7 (2.9)
MHPFOR												
Jan - Dec 13	426	25.6	11.5	14.4 (4.9)	4.2	1.4	0.9	20.6 (6.0)	13.2	-	-	4.8 (2.5)
Jan - Jul 14	357	20.2	10.4	14.0 (5.2)	3.1	1.4	1.7	20.6 (7.0)	14.0	0.6	0.6	5.1 (3.0)

Note:

1. MFU crews completed a RI-MHWQ and all MHPFOR crews completed the full version of the MHWQ.
2. (-) indicates a value of 0.0.

⁷ MFU valid % Posttraumatic stress symptoms N = 784, i.e., does not include missing data.

⁸ MFU valid % Risky drinking behaviour N = 782, i.e., does not include missing data.

⁹ AUDIT Zone III: $n = 2$.

¹⁰ AUDIT Zone IV: $n = 3$.

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19. Compared to MHPFOR personnel in 2013 and 2014, a relatively similar proportion of personnel from MFU crews reported risk of psychological distress, posttraumatic stress symptoms and risky drinking behaviour. While the proportion of those from MFU crews reporting moderate risk of psychological distress (K10) was slightly lower than for MHPFOR personnel, average total scores were not significantly different between all three groups¹¹. In addition, with respect to alcohol consumption, a chi-squared test also revealed reporting of risky drinking behaviour was not significantly different between the MFU and both MHPFOR groups¹².

Mental Health outcomes for MFU personnel

20. Table 4 (over) provides a breakdown of sample demographics for personnel assigned to MFU crews between Jun 13 and Sept 14 by mental health outcomes. As shown, the MFU sample predominately consisted of males aged over 25 years, of junior sailor rank, who had completed more than 5 years of Service in the ADF.

21. **Psychological distress:** Approximately eleven percent (11.1%, $n = 88$) of screened MFU personnel scored above the risk cut-off for symptoms associated with psychological distress, which appears comparable to the rate reported by MHPFOR (2013) personnel (11.5%). Further investigation and statistical testing of the MFU data for risk of psychological distress revealed that there were no statistically significant differences between proportions of those who scored above the risk cut-off by gender, age, rank or years served in the ADF¹³.

22. **Posttraumatic stress symptoms:** Just under six percent of screened MFU personnel scored above the risk cut-off score for posttraumatic stress symptoms (5.7%, $n = 45$). This was slightly lower than the rate reported for MHPFOR (2013) personnel (6.5%) As for psychological distress, further investigation and statistical testing of the MFU data for posttraumatic stress symptoms revealed that there were no significant differences between the proportions of those who scored above the risk cut-off by gender, age, rank and years served in the ADF.

23. **Risky drinking behaviour:** Fourteen percent ($n = 111$) of the screened MFU cohort met the criteria for risky drinking behaviours (AUDIT score ≥ 8 ; consuming alcohol in excess of low risk guidelines). This is slightly higher than the rate reported in the MHPFOR (2013) group (13.2%), however, a small proportion of members reported scores within Zone III (Hazardous, $n = 2$) and Zone IV (High Risk, $n = 3$).

¹¹ MHPFOR (2013): $\chi^2 = 0.046$ (1), $p > .05$; MHPFOR (2014): $\chi^2 = 0.137$ (1), $p > .05$.

¹² MHPFOR (2013): $\chi^2 = 0.223$ (1), $p > .05$; MHPFOR (2014): $\chi^2 = 0.200$ (1), $p > .05$.

¹³ Refer to Annex B for a detailed summary of significance testing on mental health outcomes by demographics.

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Table 4: Demographics for MFU personnel (Jun 13 – Sep 14) by the prevalence of psychological distress symptoms, posttraumatic stress symptoms and risky drinking behaviour.

	N	%	% Psychological distress			% Posttraumatic stress symptoms			% Risky drinking behaviour		
			n	%	\bar{x} (SD)	n	%	\bar{x} (SD)	n	%	\bar{x} (SD)
MFU (Jun 13 – Sep 14)	793	100	88	11.1	13.9 (4.7)	45	5.7	20.0 (4.7)	111	14.0	4.8 (3.0)
Gender											
Male	634	80.0	62	9.8	13.7 (4.4)	31	4.9	19.8 (4.5)	103	16.2	5.0 (3.1)
Female	158	19.9	26	16.5	14.8 (5.6)	14	8.9	20.6 (5.4)	8	5.1	3.8 (2.1)
Age (years)											
<25	292	36.8	36	12.3	14.1 (4.7)	16	5.5	19.8 (4.6)	50	17.1	5.0 (3.0)
25 – 34	323	40.7	37	11.5	14.2 (5.0)	25	7.7	20.6 (5.4)	46	14.2	4.9 (3.0)
35+	177	22.3	15	8.5	13.0 (4.0)	4	2.3	19.3 (3.5)	15	8.5	4.1 (2.8)
Rank											
Junior Sailor	554	69.9	63	11.4	14.1 (4.9)	34	6.1	20.1 (4.9)	88	15.9	4.9 (3.2)
Senior Sailor	128	16.1	10	7.8	13.1 (3.7)	6	4.7	19.9 (4.6)	11	8.6	4.0 (2.7)
Officer	111	14.0	15	13.5	14.1 (4.8)	5	4.5	19.6 (4.0)	12	10.8	4.7 (2.2)
Years of Service											
≤ 1	55	7.0	6	10.9	13.8 (4.4)	4	7.3	20.6 (6.4)	9	16.4	5.0 (2.9)
2-4	286	36.1	35	12.2	14.3 (4.9)	13	4.5	19.7 (4.2)	52	18.2	5.2 (3.1)
5+	442	55.7	47	10.6	13.7 (4.6)	27	6.1	20.1 (4.8)	50	11.3	4.5 (3.0)

Notes:

1. Psychological distress refers to scores at or above 20 on the K10, posttraumatic stress symptoms refers to scores of 30 or above on the PCL-C and risky drinking behaviour refers to scores of 8 or above on the AUDIT.
2. \bar{x} - Mean.
3. SD – Standard Deviation.

24. While further investigation of the AUDIT data revealed no statistically significant results for age, rank and years of service in the ADF¹⁴, a statistically significant result was found for gender¹⁵. This finding indicates that for personnel assigned to MFU crews, males were more likely to report risky drinking behaviours compared to females. It should be noted that this is consistent with higher rates of risky alcohol consumption in males, compared to females in the ADF¹⁶. For a detailed summary of the mental health outcomes for MFU crews, reported by demographics and risk category, refer to Annex C.

¹⁴ Refer to Annex B for a detailed summary of significance testing on mental health outcomes by demographical category.

¹⁵ $\chi^2 = 13.13 (1), p > .01$, Cramer's V = 0.13.

¹⁶ McFarlane, et. al. (2011). *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study: Full report*. Department of Defence: Canberra.

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Potentially Traumatic Events

25. Table 5 shows the proportion of MHPFOR 2013, MHPFOR 2014 (to Jul 14), and MFU personnel who reported exposure to a Potentially Traumatic Events (PTE) in the 12 months prior to completing a psychological screen.

Table 5: Percent of RESOLUTE 2013, RESOLUTE Jan 14 – Jul 14, and MFU personnel reporting exposure to PTEs.

Potentially traumatic event	MHPFOR 2013 (N = 426)		MHPFOR Jan 14 – Jul 14 (N = 357)		MFU (N = 793)	
	n	%	n	%	n	%
You were witness to human degradation and misery on a large scale	197	46.2	120	33.6	221	27.9
You were in danger of being injured	157	36.9	103	28.9	134	16.9
You heard of a close friend or co-worker who has been injured, killed <i>or</i> died	95	22.3	101	28.3	179	22.6
You feared that you had been exposed to disease/toxic agent	75	17.6	47	13.2	41	5.2
You saw dead bodies/human remains	72	16.9	51	14.3	137	17.3
You were in danger of being killed	68	16.0	49	13.7	46	5.8
You heard of a loved one who had been injured <i>or</i> killed	62	14.6	69	19.3	79	10.0
You were present when a close friend or co-worker was injured, killed <i>or</i> died	37	8.7	25	7.0	44	5.5
You handled dead bodies/human remains	35	8.2	27	7.6	44	5.5
You were present when loved one was injured <i>or</i> killed	8	1.9	11	3.1	9	1.1
You believed your actions or inaction resulted in someone being seriously injured	3	0.7	7	2.0	5	0.6
You believed your actions or inaction resulted in someone being killed	-	-	4	1.1	7	0.9

Notes: (-) indicates a value of 0.0.

26. Overall, compared to MHPFOR crews, MFU personnel assigned to RESOLUTE reported lower rates of exposure for all listed PTEs, with the exception of 'You saw dead bodies/human remains'. In addition, with the exception of the PTE: 'Witnessed human degradation/misery on a large scale', a different exposure 'profile' was also reported by personnel assigned to MFU crews. That is, different levels of exposures of particular PTEs were reported between MHPFOR and MFU crews. Results show that the four most commonly reported PTEs for MFU personnel were:

- a. exposure to witnessing human degradation¹⁷;
- b. hearing of a close friend or co-worker who had been injured **or** killed **or** had died;
- c. exposure to dead bodies/human remains; and
- d. in danger of being injured.

¹⁷ 'Witnessing human degradation' includes witness to human degradation and misery including refugee camps, starvation, disease, overcrowded and dangerous boats, and desperate people.

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27. Table 6 compares the mental health outcomes for MFU and MHPFOR (2013) personnel who reported exposure to at least one PTE, with personnel who reported no exposure to a PTE.

Table 6: Exposure to PTEs by mental health outcomes for MFU personnel (Jun 13 – Sep 14).

	<i>n</i>	% Psychological distress ¹ (<i>n</i>)	% Posttraumatic stress symptoms ² (<i>n</i>)	% Risky drinking behaviour ³ (<i>n</i>)
MFU (Jun 13 – Sep 14):				
Witnessed no PTE	375	7.2 (27)	1.9 (7)	11.9 (44)
Witnessed at least one PTE	401	15.0 (60)	9.3 (37)	16.7 (66)
MHPFOR (2013):				
Witnessed no PTE	134	5.2 (7)	3.0 (4)	8.2 (11)
Witnessed at least one PTE	291	14.4 (42)	8.2 (24)	15.5 (45)

Notes:

1. Percent of sample reporting 20 or above on the K10 at POPS.
2. Percent of sample reporting 30 or above on the PCL-C at POPS.
3. Percent of sample reporting 8 or above on the AUDIT at POPS.

28. As shown in Table 6, rates of psychological distress, posttraumatic stress symptoms and risky drinking were noticeably greater in the group who witnessed at least one PTE compared to personnel who did not report a PTE. These results are similar to those previously reported for MHPFOR personnel.

29. Table 7 (over) presents a breakdown of the rates of reported exposure to PTEs. These results largely reflect those reported previously for MHPFOR personnel assigned to RESOLUTE. Only the five most commonly reported events in the screened MFU personnel are shown. In the case of all the listed PTEs, and with the exception of witnessing human degradation, the majority of personnel (> 92.3%, *n* = 732) reported experiencing an event less than five times.

~~FOR OFFICIAL USE ONLY~~**Table 7: Proportion of MFU personnel reporting a PTE by the number of times experienced.**

Potentially traumatic event	<i>n</i>	% One time	% Two to four times	% Five to nine times	% Ten or more times
Witnessed human degradation / misery on a large scale	221	15.4 (34)	24.4 (54)	15.8 (35)	44.3 (98)
You heard of a close friend or co-worker who has been injured, killed or died	179	70.4 (126)	27.4 (49)	1.7 (3)	0.6 (1)
You saw dead bodies/human remains	137	23.4 (32)	63.5 (87)	8.0 (11)	5.1 (7)
You were in danger of being injured	134	45.5 (61)	32.1 (43)	8.2 (11)	14.2 (19)
You heard of a loved one who had been injured/killed	79	83.5 (66)	15.2 (12)	1.3 (1)	-

Notes:

1. Includes personnel who reported exposure one or more times.
2. (-) indicates a value of 0.0.
3. The proportion represents the % of personnel who reported witnessing the PTE.

30. With regard to witnessing human degradation, over half of personnel who reported that they experienced this PTE indicated that they witnessed the PTE five or more times (60.1%, $n = 133$). Over 44% reported experiencing the event ten times or more. The higher occurrence of witnessing human degradation reported by RESOLUTE personnel may be due to the nature of the tasks (e.g., Safety of Life at Sea rescues) encountered on RESOLUTE, as previously highlighted¹⁸.

Morale

31. Results for the RI-MHWQ indicate that more personnel assigned to MFU crews agreed¹⁹ (48.8%) than disagreed²⁰ (21.7%) that their personal morale was generally high in the 12 months prior to the screen. While the pattern was the same regarding crew morale, the proportions were of a different magnitude – a smaller proportion agreed crew morale was high (34.7%), whereas a greater percentage of personnel disagreed (28.6%) that crew morale was high compared to personal morale (refer to Annex D for detailed results). Again, this replicates results provided previously for MHPFOR personnel.

¹⁸ DOPHA Research Report 14/2014, *OP RESOLUTE Mental Health and Wellbeing Questionnaire: Surveillance Report for Jun 11 – Jul 14*, of Sep 14.

¹⁹ Personnel who responded 'Agree' or 'Strongly Agree'.

²⁰ Personnel who responded 'Disagree' or 'Strongly Disagree'.

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Homecoming Concerns

32. The RI-MHWQ asks members to indicate whether they expect to experience any difficulties when returning home from operational duty, and if so, what difficulties they expect to encounter. The majority of MFU personnel (85.9%, n = 681) reported that they had no homecoming concerns and 10.0% (n = 79) reported that they were uncertain. Table 8 below outlines the proportion of personnel who anticipated homecoming concerns, and summarises the most common reported difficulties.

Table 8: Homecoming concerns for MFU personnel (Jun 13 – Sep 14)

Expect difficulties on return to home	%	n
	3.8	30
Expected difficulties returning home (comments):		
1. Difficulty in resuming 'normal' family routines.		16
2. Issues with partner and/or children.		8
3. Stress; difficulty 'winding' down; difficulties sleeping.		6

Note:

1. Percentages are not given for qualitative responses as one respondent may list several individual responses; rather the total number of personnel who have left comments regarding the theme is given.

33. As shown in Table 8, the most common homecoming concern was anticipation of difficulties in resuming 'normal' family routines. This is consistent with the most frequently reported concern for MHPFOR (2013) personnel. To a lesser extent, MFU personnel also reported concerns related to relationships with partners and children (problems reconnecting with partners and/or expected difficulties re-establishing relationships with their children) and managing stress (including sleeping difficulties).

General Health and Wellbeing

34. As with the MHWQ, the RI-MHWQ asks personnel to self-rate their overall health over the previous 12 months. An analysis of 'perceived overall health' by 'mental health symptoms' was conducted to determine whether personnel reporting as being *at risk* on a screen, rated their general health poorer than personnel who did not report being *at risk*.

35. Compared to MFU personnel who reported low risk of psychological distress, a greater percentage of personnel *at risk* reported poorer general health. The trend was similar for personnel who reported *at risk* for posttraumatic stress symptoms (see Annex D for further details).

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36. Table 9 presents the proportion of screened MFU personnel deployed on RESOLUTE reporting different severities of sleep difficulties, compared to MHPFOR (2013) personnel.

Table 9: Reported sleep problems in the MFU personnel (Jun 13 – Sep 14) compared to MHPFOR (2013) personnel.

	N	No % (n)	Mild % (n)	Moderate % (n)	Severe % (n)	Very Severe % (n)
MFU (Jun 13 – Sep 14):						
Difficulty falling asleep	793	49.9 (396)	25.1 (199)	20.2 (160)	4.0 (32)	0.8 (6)
Difficulty staying asleep	792	55.9 (443)	22.8 (181)	15.0 (119)	5.4 (43)	0.8 (6)
Waking up too early	791	52.8 (419)	23.2 (184)	17.7 (140)	5.4 (43)	0.6 (5)
MHPFOR (2013):						
Difficulty falling asleep	426	42.5 (181)	35.2 (150)	16.4 (70)	5.6 (24)	0.2 (1)
Difficulty staying asleep	424	53.1 (226)	27.9 (119)	13.8 (59)	4.0 (17)	0.7 (3)
Waking up too early	424	47.9 (204)	31.2 (133)	13.6 (58)	6.1 (26)	0.7 (3)

37. The results presented in Table 11 indicated close to a quarter of screened MFU personnel experienced significant (i.e., ‘*moderate*’ to ‘*very severe*’) sleep problems:

- a. 25.0 % (n = 198) reported at least moderate difficulties falling asleep;
- b. 21.2 % (n = 168) reported at least moderate difficulties staying asleep; and
- c. 23.7 % (n = 188) reported at least moderate difficulties waking too early.

38. These reported rates for MFU personnel were slightly higher than for those personnel reporting the same sleep difficulties on MHPFOR crews (22.2%, 18.5% and 20.4% respectively).

39. Further investigation of responses to sleep items also revealed that the majority of those who indicated that they had ‘*moderate*’ to ‘*very severe*’ difficulties falling asleep also reported both ‘*moderate*’ to ‘*very severe*’ difficulties staying asleep (77.4%), and difficulties waking early (60.6%). This suggests that those reporting difficulties on one sleep item were also likely to report difficulties with the other items. It should also be noted that although there is no comparison group for the sleep items, the quality and quantity of sleep in deployed military personnel has been shown to be significantly poorer than non-deployed personnel (Seeling et al., 2010).

40. The morale, career intentions and general health outcomes of MFU personnel assigned to RESOLUTE are presented in further detail in Annex D.

~~FOR OFFICIAL USE ONLY~~**CONCLUSION**

41. This report presented the mental health outcomes of 793 MFU personnel deployed on RESOLUTE for the period of Jun 13 to Sep 14. Where applicable, the report compared data to MHPFOR personnel (also deployed on RESOLUTE) for the period of Jan to Dec 13 and/or Jan to Jul 14, to provide a pertinent reference point for operational mental health outcomes. This comparison was made as it measured a similar population, within similar time-frames, on the same operation (RESOLUTE). This report also presented information on screened MFU members' perceptions of workplace and deployment factors, such as homecoming concerns and morale, within a 16-month period.

42. Compared to MHPFOR (2013) personnel, members assigned to MFU crews reported no significant differences in rates of psychological distress, posttraumatic stress symptoms and alcohol related behaviour. While males in MFU crews were significantly more likely to engage in risky drinking behaviour than females, this is consistent with overall ADF prevalence results.

43. Following administration of the RI-MHWQ, 18% of screened MFU personnel required a follow-up screening interview with a psychologist. As identified, this screening interview rate is likely to have been inflated. A more reflective screening interview rate based on RI-MHWQ clinical scores was estimated at 13.5%. Following the screening interview with a psychologist, 4.5% of MFU personnel were referred for follow-up assessment with a Mental Health professional. Overall, this rate is slightly below the MHPFOR referral rate (5.6%). No urgent referrals (within 72 hours) were made for screened MFU personnel during the reporting period.

44. Compared to MHPFOR personnel, lower overall rates of PTEs were reported by MFU crews assigned to RESOLUTE. However, as for MHPFOR personnel, the higher reported exposure of '*witnessing human degradation*' is likely to be reflective of the border protection roles carried out by personnel deployed on RESOLUTE. While this PTE was reported most frequently for both MHPFOR and MFU crews, those on MFU crews reported a different overall 'exposure profile'. Regardless, personnel who reported at least one PTE were also more likely to experience psychological distress, posttraumatic stress symptoms and engage in risky drinking behaviours.

45. With respect to morale and health in the last 12 months prior to the screen, perceptions of the deployment experience and homecoming concerns:

- a. almost half of MFU personnel agreed that their personal level of morale was generally high;
- b. the majority of personnel rated their general health as '*good*' or better;
- c. more personnel rated their overall experience on RESOLUTE as positive than negative; and
- d. few reported having homecoming concerns.

46. The RESOLUTE screening and ongoing surveillance program enables the monitoring of changes to mental health outcomes over time. This informs the development and implementation of programs and policies to help address key mental health issues identified from RESOLUTE. Furthermore, ongoing screening with both the full version of the MHWQ and the RI-MHWQ will facilitate more comprehensive reporting of mental health outcomes for RESOLUTE personnel in comparison with other deployed Navy groups.

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~~FOR OFFICIAL USE ONLY~~ANNEX A
JHC RR 16/2014**Mental Health Surveillance Instruments*****Traumatic Stress Exposure Scale – Revised (TSES-R)***

1. The TSES-R (Hodson, 2002; Swann & Hodson, 2004) quantifies exposure and responses to 12 generic clusters of potentially traumatic events. The instrument contains three separate scales – *How often did you experience the event? How did it affect you at the time? How does it affect you now?* The scoring for the first scale ranges from 0 = *never* to 4 = *very often*. The scoring for the remaining two scales ranges from 0 = *not at all* to 3 = *a great deal*. Currently, there are no cut-offs for this instrument; however interviewers use their judgment to determine whether the reported exposure and its impact have significantly affected the individual.

Psychological distress

2. The Kessler 10 (K10; Kessler, et al. 2002) indicates level of psychological distress in the areas of depression and anxiety. Personnel are asked to respond to a series of ten questions by indicating on a 5-point scale (5 = all of the time to 1 = none of the time) how they have been feeling over the past four weeks. Scores on each item are added to yield a K10 total score with a range from 10 to 50. A review of K10 cut-offs in the ADF (PRTG, 2008) suggest a score of 20 or higher would be a useful marker for identifying high risk individuals in the ADF, as individuals with this score or higher have at least four times the population risk of having a depressive or anxiety disorder (Furukawa et al., 2003). The following risk groups are used for descriptive purposes in the current report: 10-14 Low; 15-19 Moderate; 20-50 High. The use of these cut-offs is recommended in Health Bulletin No 11/2009, with interviewers advised to provide relevant psycho-education and information on self-help techniques, as well as referral for a more thorough assessment if required (HB, 11/2009).

Post-traumatic stress symptoms

3. The PCL-C (Weathers, Litz, Herman, Huska & Keane, 1993) is a self-report checklist based on key diagnostic criteria for post-traumatic stress disorder (PTSD). Personnel are asked to respond to a list of problems and complaints by indicating on a 5-point scale (1 = not at all to 5 = extremely) how much they have been bothered by that problem in the past month. A total score is computed by summing the 17 items. Possible scores range from 17 to 85. A review of PCL-C by Nicholson (2006), suggests a score of 30 proves effective in identifying sub-clinical symptoms of PTSD or those possibly under-reporting symptom severities. Furthermore, a paper by Bliese et al. (2008) on a US military population suggests using a cut-off of 30 for clinical risk of PTSD in settings where the PCL is used to screen members using identifiable information and potentially resulting in referral. This lower cut-off is recommended in HB 11/2009. The following risk groups are used for descriptive purposes in this report: 17-29 Low; 30-39 Medium; 40-49 High; 50-85 Very High.

Risky Drinking

4. The AUDIT was developed by the World Health Organisation (WHO) as a screening instrument for hazardous and harmful alcohol consumption (Saunders et al., 1993; Saunders, Aasland, Amundsen & Grant, 1993). It incorporates questions about drinking quantity, frequency, and binge behaviour along with questions about consequences of drinking. It should be noted that hazardous or harmful alcohol use does not automatically equate to a diagnosis of alcoholism (HB 11/2009).

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5. In the WHO validation study, 92% of those diagnosed as having hazardous or harmful alcohol usage had an AUDIT score of 8 or more, and 94% of those with nonhazardous consumption had a score of less than 8. Further research has suggested that a cut-off of 8 accurately predicts problematic drinking (Allen, Litten, Fertig, & Babor, 1997).
6. As indicated in the Defence Health Bulletin 11/2009, individuals scoring:
- a. **Zone I** (scores of 0–7) are regarded as low risk drinkers (or may be abstinent);
 - b. **Zone II** (scores of 8–15) are consuming alcohol in excess of low risk guidelines;
 - c. **Zone III** (scores of 16–19) indicates hazardous and harmful levels of alcohol consumption; and
 - d. **Zone IV** (scores of 20 to 40) indicates that the person falls into the high risk category of alcohol-related harm.

~~FOR OFFICIAL USE ONLY~~ANNEX B
JHC RR 16/2014

Summary of Significance Testing Results

Table B1: Chi Square results for *gender* by mental health outcome measures.

Outcome:	Gender:	Low Risk:	At Risk:	χ^2
Psychological Distress (K10)	Male	572	62	5.16
	Female	136	26	
Posttraumatic Stress (PCL-C)	Male	603	31	3.72
	Female	144	14	
Risky drinking Behaviour (AUDIT)	Male	531	103	13.13
	Female	150	8	

Note:

1. Figures reported for Low and At Risk are frequencies (n) and represent the number reporting below and above the cut-off for respective mental health outcome measures.
2. A Bonferroni adjustment for significance was used (0.01);
3. Degrees of freedom (df) = 1; and
4. With a significance (p) of 0.017 and $df = 1$, the χ^2 critical value is 6.63.

Table B2: Chi Square results for *age* by mental health outcome measures.

Outcome:	Age (Years):	Low Risk:	At Risk:	χ^2
Psychological Distress (K10)	<25	256	36	1.72
	25 – 34	286	37	
	35+	162	15	
Posttraumatic Stress (PCL-C)	<25	276	16	6.44
	25 – 34	298	25	
	35+	173	4	
Risky drinking Behaviour (AUDIT)	<25	242	50	6.86
	25 – 34	277	46	
	35+	162	15	

Note:

1. Figures reported for Low and At Risk are frequencies (n) and represent the number reporting below and above the cut-off for respective mental health outcome measures.
2. A Bonferroni adjustment for significance was used (< 0.01);
3. Degrees of freedom (df) = 2; and
4. With a significance (p) of 0.01 and $df = 2$, the χ^2 critical value is 9.21.

~~FOR OFFICIAL USE ONLY~~**Table B3: Chi Square results for *rank* by mental health outcome measures.**

Outcome:	Rank:	Low Risk:	At Risk:	χ^2
Psychological Distress (K10)	Junior Sailor	491	63	2.10
	Senior Sailor	118	10	
	Officer	96	15	
Posttraumatic Stress (PCL-C)	Junior Sailor	520	34	0.74
	Senior Sailor	122	6	
	Officer	106	5	
Risky drinking Behaviour (AUDIT)	Junior Sailor	466	88	5.68
	Senior Sailor	117	11	
	Officer	99	12	

Note:

1. Figures reported for Low and At Risk are frequencies (*n*) and represent the number reporting below and above the cut-off for respective mental health outcome measures.
2. A Bonferroni adjustment for significance was used (< 0.01);
3. Degrees of freedom (df) = 2; and
4. With a significance (*p*) of 0.01 and df = 2, the χ^2 critical value is 9.21.

Table B4: Chi Square results for *years of service* by mental health outcome measures.

Outcome:	Years Service:	Low Risk:	At Risk:	χ^2
Psychological Distress (K10)	≤ 1	49	6	0.45
	2-4	251	35	
	5+	395	47	
Posttraumatic Stress (PCL-C)	≤ 1	51	4	1.10
	2-4	273	13	
	5+	415	27	
Risky drinking Behaviour (AUDIT)	≤ 1	46	9	6.97
	2-4	234	52	
	5+	392	50	

Note:

1. Figures reported for Low and At Risk are frequencies (*n*) and represent the number reporting below and above the cut-off for respective mental health outcome measures.
2. A Bonferroni adjustment for significance was used (< 0.01);
3. Degrees of freedom (df) = 2; and
4. With a significance (*p*) of 0.01 and df = 2, the χ^2 critical value is 9.21.

~~FOR OFFICIAL USE ONLY~~ANNEX C
JHC RR 16/2014

Mental Health of Personnel Deployed to OP RESOLUTE in 2013

Table C1: Psychological distress (as measured by the K10) by risk for MFU personnel deployed on RESOLUTE.

	N	%	Psychological distress					
			Low (10-14)		Moderate (15-19)		High (≥20)	
			<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total	793	100	553	69.7	152	19.2	88	11.1
Gender								
Male	634	80.0	446	70.3	126	19.9	62	9.8
Female	158	20.0	106	67.1	26	16.5	26	16.5
Age								
<25	292	36.8	193	66.1	63	21.6	36	12.3
25-34	323	40.7	220	68.1	66	20.4	37	11.5
35+	177	22.3	139	78.5	23	13.0	15	8.5
Rank								
Junior Sailor	554	69.9	384	69.3	107	19.3	63	11.4
Senior Sailor	128	16.1	97	75.8	21	16.4	10	7.8
Officer	111	14.0	72	64.9	24	21.6	15	13.5
Years of Service								
≤ 1	55	6.9	36	65.5	13	23.6	6	10.9
2-4	286	36.1	195	68.2	56	19.6	35	12.2
5+	442	55.7	314	71.0	81	18.3	47	10.6

Note:

1. N – total sample size
2. *n* – subsample size

~~FOR OFFICIAL USE ONLY~~**Table C2: Posttraumatic stress symptoms (as measured by the PCL-C) by risk for MFU personnel deployed on OP RESOLUTE.**

Posttraumatic stress symptoms										
	N	%	Low (17-29)		Medium (30-39)		High (40-49)		Very high (≥50)	
			<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total	793	100	739	93.2	35	4.4	9	1.1	1	0.1
Gender										
Male	627	79.1	596	95.1	25	3.9	5	0.8	1	0.2
Female	156	19.7	142	91.0	10	6.3	4	2.5	-	-
Age										
<25	288	36.3	272	94.4	13	4.5	2	0.7	1	0.3
25-34	318	40.1	293	92.1	19	6.0	6	1.9	-	-
35+	177	22.3	173	97.7	3	1.7	1	0.6	-	-
Rank										
Junior Sailor	554	69.9	514	92.8	26	4.7	7	1.3	1	0.2
Senior Sailor	128	16.1	121	94.5	5	3.9	1	0.8	-	-
Officer	109	13.7	104	95.4	4	3.7	1	0.9	-	-
Years of Service										
≤ 1	54	6.8	50	92.6	2	3.7	1	1.9	1	1.9
2-4	282	35.6	269	95.4	11	3.9	2	0.7	-	-
5+	438	55.2	411	93.8	21	4.8	6	1.4	-	-

Note:

1. (-) indicates a value of 0.0
2. N – total sample size
3. *n* – subsample size

~~FOR OFFICIAL USE ONLY~~**Table C3: Risky drinking behaviour (as measured by the AUDIT) by risk for MFU personnel deployed on OP RESOLUTE.**

	Risky drinking behaviour									
	N	%	Zone I		Zone II		Zone III		Zone IV	
			<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total	793	100	671	84.6	106	13.4	2	0.3	3	0.4
Gender										
Male	626	78.9	523	83.5	98	15.7	2	0.3	3	0.5
Female	155	19.5	147	94.8	8	5.2	-	-	-	-
Age										
<25	288	36.3	238	82.6	49	17.0	-	-	1	0.3
25-34	317	40.0	271	85.5	43	13.6	1	0.3	2	0.6
35+	176	22.2	161	91.5	14	8.0	1	0.6	-	-
Rank										
Junior Sailor	544	68.6	456	83.8	84	15.4	1	0.2	3	0.6
Senior Sailor	127	16.0	116	91.3	10	7.9	1	0.8	-	-
Officer	111	14.0	99	89.2	12	10.8	-	-	-	-
Years of Service										
≤ 1	55	6.9	46	83.6	9	16.4	-	-	-	-
2-4	281	35.4	229	81.5	50	17.8	1	0.4	1	0.4
5+	436	55.0	386	88.5	47	10.8	1	0.2	2	0.5

Note:

1. (-) indicates a value of 0.0
2. N – total sample size
3. *n* – subsample size

~~FOR OFFICIAL USE ONLY~~ANNEX D
JHC RR 16/2014**Morale, Mental Health and General Health Outcomes of MFU Personnel****Table D1: Personal and crew morale of MFU personnel²¹**

Morale	% Disagree	% Ambivalent	% Agree
Personal	21.7 (172)	29.1 (231)	48.8 (387)
Crew	28.6 (227)	35.6 (282)	34.7 (275)

Note:

1. % Agree – combined responses of ‘Agree’ and ‘Strongly Agree’
2. % Disagree – combined responses of ‘Disagree’ and ‘Strongly Disagree’
3. % Ambivalent = % of response ‘Neither Agree nor Disagree’

Table D2: General health outcomes of MFU personnel (Jun 13 – Sep 14).

	% Excellent	% Very good	% Good	% Fair	% Poor
General Health	7.8 (62)	33.4 (265)	47.7 (378)	8.8 (70)	1.5 (12)

1. **Psychological Distress.** As seen in Table D3 below, when compared to personnel who reported *low risk* of psychological distress, a greater percentage of personnel *at risk* of psychological distress reported their general health to be ‘poor’ or ‘fair’.

Table D3: Mental Health compared to General Health and Wellbeing Outcomes of MHPFOR Personnel.

		General Health	
		Poor	Fair
Psychological Distress	Low Risk	0.9	6.2
	At Risk	6.8	30.7
Posttraumatic Stress Symptoms	Low Risk	1.1	8.0
	At Risk	4.4	22.2

Note: All figures are percentages.

²¹ Screened personnel were asked about their level of agreement (from ‘Strongly Disagree’ to ‘Strongly Agree’) on two morale items: (i) ‘In the past 12 months my personal level of morale has been generally high’ (Personal); and (ii) ‘In the past 12 months the overall level of morale in the crew has been high’ (Crew).

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2. **Posttraumatic Stress Symptoms.** Table D3 also shows that the trend was similar for personnel who reported at risk for posttraumatic stress symptoms. This trend was not found for risky drinking behaviour, however, where results for general wellbeing were similar for personnel reporting risky drinking behaviour and those not.

Table D4: MFU Personnel (Jun 13 – Sep 14) rating of overall experience on RESOLUTE

	Very Positive % (n)	Positive % (n)	Neither Negative or Positive % (n)	Negative % (n)	Very Negative % (n)
Overall RESOLUTE Experience	2.0 (16)	34.2 (271)	48.5 (385)	13.0 (103)	0.9 (7)

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