

SENATE ESTIMATES BRIEF

Personnel 03
Secretary's and CDF's pack

PERSONNEL 03: SUPPORT FOR PHYSICALLY AND MENTALLY INJURED AND ILL ADF PERSONNEL

Key Facts

<ul style="list-style-type: none"> • Since 2002 282 personnel have been wounded across the Middle East Area of Operations (to 1 May 2013): <ul style="list-style-type: none"> • 252 in Afghanistan; and • 30 in Iraq. • In Financial Year 2011-12 a return to work rate of 76% was achieved by the ADF Rehabilitation Program. 	<p>Key initiatives:</p> <ul style="list-style-type: none"> • Support for Wounded Injured or Ill Program (SWIIP). • Chief of Army Wounded Injured and Ill Digger Forum. • Soldier Recovery Centres. • ADF Mental Health Reform Program. • Simpson Assistance Program.
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Key Issues

- Providing the necessary care and support to ADF personnel who are wounded, injured or ill is one of Defence's highest priorities.
- We have been improving the way we provide care and support through a range of initiatives including the Support for Wounded, Injured or Ill Program (SWIIP), a joint initiative between Defence and Veterans' Affairs.
- SWIIP is enabling us to reduce complexity, clarify roles and responsibilities, enhance the support that we provide to seriously wounded, injured or ill members, and improving the way that we share information between the two Departments.
- To date, 26 of the 31 recommendations have been completed with work on a further four recommendations expected to be completed by mid 2013.
- Work under SWIIP has included the development of a new Memorandum of Understanding (MoU) between Defence and Veterans' Affairs for the

Cooperative Delivery of Care and Support to Eligible Persons signed on 5 February 2013.

ADF Mental Health Initiatives

- The ADF Mental Health Reform Program (\$84 million over four years) was initiated in 2009 in response to the Dunt Report.
 - The program has provided evidence of the prevalence of mental health disorder in the ADF allowing us to tailor our resilience, awareness, treatment and recovery programs to the changing needs of ADF personnel and their families.
 - The program will set priority actions through to 2015 with particular attention to addressing stigma and barriers to care, responding to mental health impact of deployments, alcohol misuse, and suicide prevention.
- We are alert to the potential impact of multiple deployments on mental health and rehabilitation needs. However, our research is consistent with international findings that the number of deployments is not as predictive as the level of trauma or combat exposure. This is helping to shape our response to the needs of certain at risk groups such as Special Forces.
- The rate of suicide in the ADF is lower than in the general population and does not compare to the high rates reported in other Military Forces such as the US.

Other Initiatives

- The Simpson Assistance Program (\$71.214 million across the decade from FY10/11) is being implemented to enhance the efforts of Defence to reduce the impact of serious wounds, injury or illness on ADF personnel and their families.
 - The implementation of the Program is improving coordination and integration of existing services and developing new specialist programs, that ensure a comprehensive and tailored approach to rehabilitation and recovery.
- Work underway within Army includes the establishment of Soldier Recovery Centres and the Chief of Army Wounded Injured and Ill Digger Forum.

- The 2012 Chief of Army Wounded Injured and Ill Digger Forum focused on PTSD and cost approximately \$85,000.
- In 2013, the Chief of Army will host another Wounded Injured and Ill Digger Forum focussing on mental health injuries. A date has not yet been finalised; however, the Forum is expected to be held in the final quarter of this year.
- Soldier Recovery Centres have been established in Darwin, Townsville, Brisbane and Holsworthy.
 - Soldier Recovery Centres are funded from Forces Command/Brigade resources. Reductions in the Forces Command budget will likely impact Soldier Recovery Centre funding.

JSCFADT Questions on Notice Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Public Hearing - Tuesday 5 February 2013

In Q1, asked in writing on 7 February 2013, Ms Brodtmann inquired about treatment provisions provided for civilian defence officers posted to operational areas.

Response tabled 13 May 2013.

In Q2, asked in writing on 7 February 2013, Ms Brodtmann inquired about promotion rates of wounded / injured military personnel versus non- wounded / injured military personnel.

Response tabled 13 May 2013.

Public Hearing - Tuesday 19 March 2013

In DEF1 Mr Robert asked about rates of mental health issues in Special Forces versus Army personnel.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF2 Senator Fawcett asked about the outsourcing of the ADF health services contract.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF3 Senator Fawcett asked about statistics and satisfaction rates of ADF personnel accessing healthcare services.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF4 Senator Furner asked about employment numbers of psychologists and psychiatrists on-base pre- and post-rollout of the new ADF Health Services Contract.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF5 Senator Fawcett asked about budget pressures on ADF health capability due to decreases in budget allocations to Defence.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF6, asked in writing on 19 March 2013, Mr Adams requested information about the ADF alcohol management policy.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

In DEF7 Ms Brodtmann asked Defence to provide information on the status of PMKeyS Modernisation Projects with particular focus on whether the project will implement an identity number for an ADF individual that follows them throughout the course of their career from serving to being a veteran.

Draft response. As at 23 May 2013, the response is with the Minister awaiting approval.

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Date: 16 May 2013

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SWIIP Program Manager (Defence)
Date: 16 May 2013

CONSULTED WITH:

- Joint Health input cleared by RADM Robyn Walker, Commander Joint Health
- Army input cleared by BRIG Simone Wilkie, Chief of Staff, Army Headquarters
- Wounded statistics provided by Mr Cliff Cole, Ministerial Liaison Officer, Headquarters Joint Operations Command

BACKGROUND

Media Coverage

- The subject of mental health is frequently reported on in the media.
- MAJGEN John Cantwell published a book titled "Exit Wounds: One Australian's War on Terror" on 26 September 2012 about his experiences at war as well as his experience with Post Traumatic Stress Disorder (PTSD).
- MAJGEN Cantwell appeared on Channel 7's Sunday Night program in September, and on Lateline on 24 September 2012.

Support for Wounded, Injured or Ill Program.

- SWIIP arose out of a 2010 gap analysis which concluded that, while the existing support systems were generally good and resulted in a high return-to-work rate for rehabilitated members, more could be done. The resulting report recommended 'end-to-end' systemic change and a renewed partnership and greater understanding between Defence and the Department of Veterans' Affairs.
- Phase One of, what was then, the Support for Injured or Ill Project (SIIP) was conducted between August and December 2010. This Phase included a gap analysis of Defence, single Service and Veterans' Affairs incident reporting, welfare, health care, rehabilitation, compensation and transition policies, processes and services.
- The Phase One report concluded that the system supporting injured or ill Defence members is generally good and results in a high return-to-work rate for rehabilitated members. However, the report confirmed that a more coordinated and integrated approach across welfare, rehabilitation, compensation and transition programs would improve outcomes for ADF members and their families and better support commanders in meeting their responsibilities.
- The Phase One report was made publically available via the Defence Internet site in April 2012.
- Following consideration, Defence and Veterans' Affairs jointly initiated Phase Two of the Program, renamed the Support for Wounded, Injured or Ill Program, to implement the 31 Phase One recommendations and develop an integrated, seamless and member-centric support system that meets the need of wounded, injured or ill members during their service career and after transition from the ADF.
- This integrated support system is known as the Support Continuum and incorporates the key support processes that operate within both Departments in support of wounded, injured or ill members.
- Work under Phase Two commenced in early 2011. As at 7 May 13, work on 26 of the 31 recommendations has been completed with work on a further four recommendations expected to be completed by mid 2013. Work on the last recommendation has been transferred to the continuing strategic element of SWIIP Phase Two as it requires an extended period of data gathering.
- The strategic component of SWIIP Phase 2 includes exploration of potential new initiatives and work to expand initiatives implemented earlier but where implementation was constrained by privacy considerations and/or limitations in departmental information systems. This work is expected to continue over the next four to five years.

- As the principal stakeholders, Defence and Veterans' Affairs remain committed to ensuring the interfaces, boundaries and barriers with regard to medical separation from the ADF, workplace safety, health care, rehabilitation and compensation are identified and resolved so as to ensure the resulting system is both member-centric and responsive to Command requirements.
- This joint commitment has been formally recognised in a new Memorandum of Understanding (MoU) between Defence and Veterans' Affairs for the Cooperative Delivery of Care and Support to Eligible Persons.
- The MoU, which sets out the key principles that are to underpin the relationship between Defence and Veterans' Affairs, was signed on 5 Feb 13 and is available via the Defence and Veterans' Affairs internet sites.
- SWIIP aims to substantially improve on the status quo by closing the gaps and issues identified under Phase One by:
 - Improving the overall visibility of Commanders on members who are on rehabilitation programs or on long-term convalescence leave or maternity leave and return to family and are away from their Unit;
 - Working with trainees who separate quickly to ensure that they are aware of their entitlements or the support services available to them;
 - Ensuring that Defence services recognise the role families play in supporting a member through rehabilitation; and
 - Clarifying the governance and ownership arrangements to ensure that all involved in providing support understand their role and responsibilities and that the performance of the support system is measured and monitored to ensure it is operating efficiently and effectively.
- SWIIP is about systemic change, ensuring that the support systems within and between Defence and Veterans' Affairs are seamless, correctly integrated and make certain that members remain the central focus of support. SWIIP is not about service delivery – that remains the responsibility of the relevant service providers within Defence and Veterans' Affairs.

Note: HPC has a detailed brief on SWIIP

ADF Mental Health Reform and Simpson Assistance Program

- Through the ADF Mental Health Reform Program 45 out of 52 of the Dunt review recommendations have been implemented. To support personnel across all stages of their military careers the ADF has in place:
 - eight Regional Mental Health Teams to enhance delivery of mental health care;
 - research demonstrating the profile of ADF mental health needs and prevalence rates of conditions such as Post Traumatic Stress Disorder;
 - an ADF Mental Health Strategy and implementation plan through to 2015;
 - robust post deployment screening, debrief and referral processes;
 - a suite of awareness and training programs in resilience building, suicide prevention, alcohol and other drugs and peer support;
 - promotion of mental fitness and the importance of early access to treatment for mental health disorders through the inaugural ADF Mental Health Day on 10 Oct 2012;
 - joint initiatives with my Department of Veterans' Affairs to promote awareness of the impact of PTSD and alcohol misuse and support access to care;
 - direct referral options to the Veterans and Veterans Families Counselling Service;
 - ADF suicide prevention programs and national suicide risk assessment training for ADF health providers;

- a partnership with the Australian Drug Foundation to implement an ADF Alcohol Management Strategy; and
 - outcomes of a structured third-country-location decompression program, trialed in 2011, has informed future iterations of the program for formed bodies and embedded personnel/augmentees rotating out of theatre. This trial also informed the Third Location Decompression (TLD) program for the Special Operations Task Group (SOTG), scheduled to be implemented in June 2013.
- The findings from the 2010 ADF Mental Health Prevalence and Wellbeing Study suggests that the significant resources invested by the ADF in a comprehensive operational mental health support system may be effective in prevention and early intervention for mental health disorders resulting from exposure to occupational stressors on operations.
 - Analysis of the data has not revealed a significant relationship between the number of deployments and mental health symptoms. There is a trend however, that indicates greater levels of traumatic symptomatology with each deployment. The data show a strong direct relationship between lifetime trauma exposure and mental health symptoms.
 - While more detailed analysis will be needed, consistent with international literature, it is likely that the number of deployments is not as predictive as the level of trauma or combat exposure for the level of negative mental health outcomes.
 - Deployed ADF members are provided with a continuum of mental health support designed to enhance their ability to cope with the challenges of deployment and to improve their capacity for effective transition to work and family life. Further, this continuum of care allows for early identification and intervention for those individuals considered to be at risk of developing mental health disorders.
 - The 2010 ADF Mental Health Prevalence and Wellbeing Study indicated that while 4 percent of ADF personnel had experienced some form of suicidal ideation or behaviour, and 1 percent had considered-a suicide plan, rate of attempts were similar when compared to the broader community. Our research has not found a strong relationship between operational deployment and suicide in the ADF.
 - We monitor the rate of completed suicides and when matched for age and gender demographics the number of deaths appears to be much lower than in the general community.
 - We recognise the association between suicide risk and mental health disorders, particularly depression and post traumatic stress disorder and for this reason defence is heavily engaged in screening, risk assessment and ensuring effective treatment intervention are available as early as possible.
 - The Simpson Assist Program (SAP) consists a total of 12 projects of that comprehensively invest in Defence's overall recovery capability. These projects provide:
 - Individually tailored recovery programs with an emphasis on family and peer support;
 - Meaningful engagement options that minimise unproductive convalescence leave and support ADF personnel as they prepare to return to work; and
 - Specialist psychosocial programs, online resource materials and information guides to support ADF members and their families.

 - An ADF Recovery and Rehabilitation Strategy which will outline the responsibilities and accountability for ADF recovery and rehabilitation, and appropriate governance and key performance indicators to drive service excellence.

Note- VCDF and CJHLTH have detailed Briefs on ADF Mental Health Reform Program and rehabilitation initiatives.

Joint Standing Committee on Foreign Affairs, Defence and Trade

QUESTIONS ON NOTICE – COMMITTEES

Inquiry into the care of ADF Personnel Wounded and Injured on Operations – 9 October 2012

Q1: Treatment provisions provided for civilian defence officers posted to operational areas

Ms Brodtmann asked on 7 February 2013:

What follow-up and treatment provisions are provided by the Department of Defence for civilian defence officers who have been posted to operational areas such as Afghanistan?

Response:

While in the operational area, Department of Defence Australian Public Service (Defence APS) employees are entitled to health care commensurate to that provided to deployed ADF personnel. As with ADF personnel, specific health care can differ depending upon the operation. For Afghanistan, this includes access to coalition medical and evacuation facilities.

Prior to return to Australia, Defence APS employees are given the opportunity to attend Defence-provided medical and psychological screening.

Depending on the nature of any injury or illness suffered as a consequence of their operational duty, Defence APS employees returning from an operational area may receive treatment and/or compensation through Comcare and/or psychological support through Defence's Employee Assistance Program. All ill or injured Defence APS employees are provided with rehabilitation case management support to facilitate their recovery and return to work. The provisions for this care are included in the Defence Enterprise Collective Agreement 2012-14.

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Inquiry into the care of ADF personnel Wounded and Injured on Operations – 2 February 2013****Ms Brodtmann asked on Thursday 7 February 2012:****Q2: Promotion rates of Military Personnel**

Please provide comparative figures on the rates of promotion of military personnel who have been wounded (including those with PTSD) against those of personnel who are not wounded or with PTSD.

Response:

The ADF has commenced a number of initiatives to ensure that wounded, injured or ill members are provided the support and opportunity to recover and return to their previous or new work within the ADF. On return to full duties, members are able to compete with their peers for promotion opportunities. Military personnel, who are wounded, injured or ill have access to health care services and programs such as the ADF Rehabilitation Program. This includes access to:

- specialist treatment,
- a dedicated rehabilitation consultant to support their workplace-based rehabilitation and to coordinate care arrangements, and
- non-clinical aids and appliances in support of serious and/or complex rehabilitation needs.

Defence also has a comprehensive support continuum from prevention through to treatment in place to respond to the full range of post-traumatic mental health conditions experienced by ADF members, including post-traumatic stress disorder (PTSD).

Defence does not routinely compare the rates of promotion of military personnel who have been wounded (including those with PTSD) against those of personnel who are not wounded or with PTSD.

The information sought is not readily available. To obtain such information would be an unreasonable diversion of departmental resources.

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations - 19 March 2013****DEF1: Rates of Mental Health Issues****Mr Robert MP asked on 19 March 2103, Hansard page 7:**

Rear Adm. Walker: I do not have any specific breakdown available tonight on SF versus Army. I can go back to look at the prevalence study to see if we can pull that data out.

Mr ROBERT: That would be helpful, just noting the public commentary in terms of the high rate of multiple deployments in our SF community.

Rear Adm. Walker: We have some because that will be coming out shortly as a result of the prospective study into the Middle East area of operations deployment in the census study. That data will be available publicly within the next couple of months and that may well give us some information rather than anecdote.

Mr ROBERT: We will take that on notice, Admiral – anyone - Deputy Chief of Army, in terms of how we are going supporting those suffering from mental health issues.

Response:

The 2010 ADF mental health prevalence and wellbeing study provided a comprehensive overview of the mental health of Australian Defence Force (ADF) members, demonstrating that 22% of personnel had experienced a mental disorder in the 12 months prior to the study. There were insufficient numbers of Special Forces participants to allow prevalence rates of mental health disorders within this sub-group to be estimated. The Middle East Area of Operations (MEAO) census study report and the MEAO prospective study report are expected to be released in the coming months, but these reports do not include analysis of subgroups within the ADF, such as Special Forces. However, initial analysis of the mental health symptoms measured across all three studies has indicated that the Special Forces population is slightly healthier than the broader Army population despite the high operational tempo.

Since mid-2011, Joint Health Command has worked collaboratively with Special Operations Command on a performance and wellbeing framework to enhance the physical and mental health of Special Forces personnel. This framework acknowledges the potential impact of multiple combat deployments and includes initiatives to build psychological resilience, monitor health and physical performance and provide early intervention for emerging issues.

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations - 19 March 2013****DEF2: Outsourcing of Healthcare Services****Senator Fawcett asked on 19 March 2013 Hansard page 7.**

Senator FAWCETT: My impression over the course of this inquiry is that Defence has been very proactive in responding to the conflicts, from Iraq through Afghanistan, and that the system has improved considerably. It is probably still not perfect, but I want to put it on record that it is apparent that Defence has been working hard to make the system work well. Thank you for that. Clearly for people coming back to Australia part of the health care they receive depends on how you approach it. There has been a lot of controversy over the past few months about the outsourcing to Medibank of both the garrison, through Aspen, and the referrals to specialists. Can you give us a quick update on the status of that? Are all garrisons now covered? Have all the outsourcing models been put in place.

Response:

- (1) Defence and Medibank Health Solutions (MHS) have finalised the transition of all services for the ADF Health Services contract and are commencing a steady business as usual state. In order to move the contract into this phase Defence is confident that:
 - (a) All garrisons have access to the required level of health services both on-base and off-base; and
 - (b) A sufficient level of outsourced arrangements are in place to ensure that ADF personnel continue to receive timely and clinically appropriate care within their locale.
- (2) Defence and MHS acknowledge that throughout the contract term there will be workforce pressures for the on-base services due to critical workforce levels in the health industry especially in remote localities and areas of need. The current on-base services personnel fill rate is approximately 93% nationally. Defence and MHS continue to work together on this issue to ensure sufficient fill rates for on-base personnel are achieved across the garrison environment; and that ADF personnel continue to receive timely access to high quality health care.
- (3) Defence is confident that ADF personnel have continued to receive timely, clinically appropriate care within their locale during the transition to the new off-base services arrangements. Whilst there were initial concerns regarding the sufficiency of the off-base service provider numbers Defence and MHS have worked through the sufficiency concerns to ensure appropriate access for the ADF. MHS continue to monitor, review and grow the off-base service provider list and will do so through the life of the contract to ensure appropriate, timely access is available to the ADF; and also ensure that it is aligned with Defence's changing healthcare needs. Defence will continue to work with MHS throughout the contract term to ensure ADF personnel have access to appropriate care through the off-base service provider arrangements.

Joint Standing Committee on Foreign Affairs, Defence and Trade

QUESTIONS ON NOTICE – COMMITTEES

Care of ADF Personnel Wounded and Injured on Operations - 19 March 2013

DEF3: Statistics and Satisfaction Rates

Senator Fawcett asked on 19 March 2013 Hansard page 7.

Senator FAWCETT: ...and then on notice I would be interested if you come back to us with any stats you are collecting in terms of differences in waiting times for people to see medical support, whether it be doctors or allied health professionals on garrison, or satisfaction rates and wait times etcetera for specialists. That would be a useful trend to look at before and after that implementation.

Response:

ON-BASE WAIT TIMES

Defence's "wait time" statistics measure the number of days until the first available appointment for a number of services. A number of factors impact on wait times including position vacancies across the Defence's health workforce (including ADF and APS), baseline security clearance (which affects their effectiveness in the facility and their access to electronic health systems), corporate knowledge regarding policy and processes, short notice deployments, increases in demand by the single Services and seasonal variations.

The table below compares the wait times for March 2013 (post contract) with the wait times for October 2012 (pre contract). There may be some seasonal impact on the wait times when comparing the month of March to October.

Type of appointment	Number of facilities wait time improved	Number of facilities wait time remained the same	Number of facilities wait time increased
Non-urgent medical appointment	16	25	10
Non-urgent mental health appointment	10	24	6
Non-urgent psychology appointment	16	18	7
Non-urgent physiotherapy appointment	8	24	8
On-urgent dental appointment	14	18	8

Off-Base Wait Times

Prior to the implementation of the ADF Health Service Contract, Defence did not previously collect external specialist appointment wait times as there was no system in place to do so. The implementation of the Central Appointments Team under the ADF Health Service Contract has given Defence increased visibility of external specialist wait times.

When referring an ADF member to an external specialist the referring health practitioner is required to identify the referral priority (Routine, Clinically Urgent or Operationally Urgent) and the Service Delivery Priority (Priority 1: Less than 7 days, Priority 2: 7 to 28 days and Priority 3: Greater than 28 days). The Central Appointments Team books specialist appointments in accordance with the referral and service delivery priority identified by the referring health practitioner.

The average national wait time for an appointment with the following medical specialists booked through the Central Appointments Team is:

- a) Orthopaedic Surgeon - 16 days (business days)
- b) Dermatologist - 22 days
- c) General Surgeon - 17 days
- d) Obstetrician/Gynaecologist - 18 days
- e) Otolaryngologist/Head Neck surgeon - 22 days

Satisfaction Rates

Defence undertook a customer satisfaction survey from 1 August to 31 October 2012. This survey was intended to provide a baseline of customer satisfaction prior to entering into the ADF Health Service Contract. The next iteration of the survey is scheduled to commence in September 2013. The final report is still pending however the following data is provided.

Of the 5,341 valid survey respondents who provided responses about their visit:

- 82.8% were seen within 30 minutes of their scheduled appointment;
- 34.6% were able to get an appointment in less than one week;
- 23.4 % took more that three weeks to get a non-urgent medical appointment;
- 74.2% agreed that access to the health service they required was available in a reasonable timeframe;
- 73.3% indicated that they were satisfied or very satisfied with the health service provided; and
- 64.0% agreed or strongly agreed that the overall quality of the health service they received was excellent.

Compliments and Complaints

The transparency and tracking of compliments and complaints has improved over the past year due to the implementation of new systems and processes as well as increased awareness of ADF members of the processes to report issues.

Thirty eight compliments were received in February 2013. This is the highest number recorded since September 2010. These compliments relate to treatment, professional conduct and administration.

There were 75 complaints recorded for January 13 and 138 complaints recorded for February 2013. This number of complaints is set against the context of respectively 34,152 and 54,694 episodes of

clinical treatment delivered by Defence in January and February 2013. Further context is provided by noting that in January and February 2012 the number of episodes of clinical treatment delivered by Defence was respectively 26,986 and 48,380. The most common causes for complaints in January and February 2013 are access, communication and information; and treatment.

Current Activity

Defence is currently undertaking a review of its workforce with the intention of identifying the appropriate craft group and number of personnel required to provide efficient and effective health services to ADF members at each health facility. Defence is continuing to work with Medibank Health Solutions to develop strategies to recruit to vacant positions which have proven difficult to fill. We will also continue to cross level the workforce between the facilities and seek single Service support as required in order to maximise service delivery at each location.

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations - 19 Mar 13****DEF4: Employment Numbers On-Base Pre and Post-Health Services Contract Rollout****Senator Furner asked on 19 March 2013, Hansard page 8:**

CHAIR: I have a supplementary question to Senator Fawcett's first question in respect of the Medicare transition. My understanding is that there are 36 on base psychologists, 163 off base psychiatrists and 859 off base psychologists. What I would like to know on notice is how that relates to the number of health providers prior to the Medicare transition. Rear Adm. Walker: Essentially there has been no change to the on base staff. CHAIR: For how long? Rear Adm. Walker: Prior to the contract or now. In fact, in terms of APS or ADF members, there has been no reduction in those numbers, in a sense. Positions have not been changed or abolished. We have always relied on external mental health providers, in terms of psychiatrists and psychologists, around the country. CHAIR: My question is: how does that relate to the relativities of now as opposed to pre the new contract? Rear Adm. Walker: As I say, there has been no change in the numbers of people that we would have employed in ADF or APS on-base prior to the contract or post the contract. As for contracted staff, again, I do not know whether those numbers are correct, but we have always used external providers for additional support. So there has been no decrease in providers. CHAIR: All right. Thanks. Air Marshal Binskin: Can I just address one part of the question from Senator Fawcett earlier - you were talking about numbers on bases, and we will give you the statistics for before and after. One thing the new contract has allowed us to do is adjust the numbers of providers at the different bases. As you know, we have moved Defence units around - 7RAR going to Adelaide was one of those - and this contract being put in place allowed us to adjust the numbers of medical personnel to match the numbers of people that we have on bases as well. I think you will see that when you see the stats.

Response:

Prior to the new contract Defence delivered services to the Australian Defence Force (ADF) via seven different prime contractor arrangements. Under these arrangements there were 745 full time equivalent (FTE) personnel engaged to deliver health care services on-base. Under the new contract Medibank Health Solutions (MHS) are engaged to provide 808 FTE personnel in the delivery of health care services on-base.

Specific to MHS, Defence provides access at on-base facilities through a multi-disciplinary mental health team. This on-base mental health team consists of ADF personnel, Australian Public Service (APS) personnel and contracted personnel engaged as social workers, psychologists and mental health nurses. In support of the on-base Mental Health Team; off-base service providers are utilised on an as-required basis, as deemed clinically appropriate.

The actual number of contracted personnel in the on-base mental health team has increased slightly subsequent to the transition to the new ADF Health Services contract. The total number of mental health professionals engaged prior to the new contract was 32 FTE and post the new contract is 36 FTE. Psychologists made up 17.5 FTE previously and now make up 18.5 FTE of the total numbers of mental health professionals respectively.

Prior to the MHS contract Defence did not have formal agreements with any off-base health care providers and services were sourced via any registered health professional within the civilian community on a clinically appropriate basis. Under the MHS contract Defence can still access any registered health professional within the civilian community, however, Defence now has access to a list of 176 psychiatrists and 920 psychologists who are pre-credentialed and approved with MHS.

In recognition of the varying clinical requirements and changing geographical requirements of the ADF, Defence will continue to work with MHS throughout the contract term to ensure ADF personnel have access to appropriate care

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations – 19 March 2013****DEF5: Budget Pressures on Health Capability****Senator Fawcett asked on 19 March 2013 Hansard page 8.**

Senator FAWCETT: This is my last question, and I am happy for you to provide the answer on notice. Clearly, since 2009 there have been ongoing cost growth pressures across the ADF that correspond with decreases in budget allocations. The government has worked with Defence to get appropriate decisions about your priorities, and we have heard through a number of estimates sessions that that has caused Defence to have to make decisions about where you spend the money, where the priorities are - and we accept that. What I would like to know is: in the area of health, from Joint Health Command and any other areas that feed into that, where are those trade-offs being made?

Can you give an indication of the areas where you have taken a hit or reduced some capability as a result of the budgetary pressures that have been placed on you. Rear Adm. Walker: Senator, we have not reduced the type or quantity of, or eligibility for, any health services, other than where it has been shown, based on evidence, that that would not be an appropriate treatment. If someone needs a treatment, it is provided. The cost is not the factor that decides whether or not you have treatment; it is all about your clinical need and the evidence base for having that treatment. There are no treatment services that are not provided on the basis of any budgetary restrictions. The whole point of us moving to the new contract arrangements was to better understand and manage our health budget in an environment where we knew we were being overcharged for services, which then increases the pressure on the budget. Whilst I have not been able to articulately say it before, it is not cost-cutting, because we have never refused anyone treatment; but it is about trying to manage our health budget in a more responsible way. Senator FAWCETT: Admiral Walker, you misunderstood my question. I am not accusing you of cost-cutting by making this change. I am asking you: if you look at your health capability as having fundamental inputs into capability, then where are the pressure points where you have had to make trade-offs over that ?

Response:

The Department of Defence has not reduced the type or quantity of, or eligibility for, any health care services provided to Australian Defence Force (ADF) personnel unless it has been shown, based on evidence, that the service would not be an appropriate treatment. Any decision regarding the treatment to be provided to ADF personnel is based on the clinical need and the evidence base for having that treatment. Department of Defence budgetary restrictions have not impacted the provision of health care services to ADF personnel and there has been no reduction to health capability as a result of the budgetary pressures facing the Department.

Joint Standing Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations - 19 March 2013****DEF6: ADF Alcohol Policy**

Mr Adams provided in writing on Friday 19 March 2013.

Within the culture of the ADF is there still an open bar policy at bases, and how is alcohol management being addressed?

Response:

Defence provides funding support to over 130 bars and clubs on bases around Australia, and provides bar services as part of mess facilities. Bars and clubs play an important role in Service culture and ethos. In 2012, Defence agreed to reforms to reduce and standardise bar opening hours and promote responsible management of bars across Defence. This change is consistent with initiatives being developed under Defence's *Pathway to Change Strategy* and the complementary ADF Alcohol Management Strategy. Further phases of bar reform, including consistency in bar management and alcohol pricing across Defence bars, will be finalised over the coming months for implementation later in 2013 and in 2014.

Defence provides a comprehensive suite of alcohol, tobacco and other drug services to ADF members. This includes mandatory awareness briefs, psycho-education workshops and access to a stepped care approach to appropriate garrison-based interventions in a primary care setting and referral to external specialist treatment and rehabilitation services as required.

Additionally, Defence is working closely with the Department of Veterans' Affairs in adapting its health promotion initiative, *The Right Mix – Your Health & Alcohol*, to the needs of current serving ADF members. This includes promotion of the recently released the smart phone application *On Track with The Right Mix*.

Cultural reform with regard to responsible alcohol use in the ADF is being progressed through Defence's Pathways to Change reform program and development of a comprehensive ADF alcohol management strategy.

The Australian Drug Foundation has been contracted to assist with the development of the strategy and formulation of single Service implementation plans in collaboration with each Service and Joint Health Command. The strategy is informed by and addresses the recommendations arising from the *Independent Review of Alcohol use in the ADF* conducted by Professor Margaret Hamilton in 2011.

Implementation of the strategy will strengthen the ADF approach to alcohol management by providing education and information to ADF members about responsible alcohol use; managing the availability and supply of alcohol; providing support and treatment to those who require it; and monitoring and responding to alcohol related incidents.

To support implementation of the strategy, the ADF will implement four specific resources developed with the assistance and expert advice of the Australian Drug Foundation. These include:

- (a) A review of the Defence alcohol policy aligning Defence policy with evidence based national alcohol and other drug policy;
- (b) An alcohol behaviours expectations statement which outlines the standards expected for responsible use of alcohol in the ADF;
- (c) A leader's guide to alcohol management which provides guidance to ADF commanders in relation to all aspects of alcohol use in the ADF with a particular focus on prevention and early intervention; and
- (d) A hospitality management program designed to provide guidelines for Defence in the planning and conduct of events where alcohol will be available.

These resources are important tools that will enhance the ADF's existing alcohol, tobacco and other drugs service.

Joint Committee on Foreign Affairs, Defence and Trade**QUESTIONS ON NOTICE – COMMITTEES****Care of ADF Personnel Wounded and Injured on Operations - 19 March 2013****DEF 7: PMKeYS UPDATE**

Ms Brodtmann asked on Tuesday 19 March 2013 (Hansard page 4):

Ms Brodtmann: Great. The other thing is from the Defence families association. They also spoke to us about the disconnect on a D-number between Defence and DVA, and they were proposing a sort of identity number that would follow an ADF individual throughout the course of their career from serving to being a veteran. I understand that there is a bit of work being done on that with the famous PMKeyS program, and I would be grateful for an update on where that is at. The other suggestion that they made - and I will take this quickly in committee - is the concept of a case manager not just for the individuals that are presenting to DVA but also for their families. There is a lot of misunderstanding amongst the families about what support is available to them, sometimes what the signs are. The suggestion was that we possibly have a case manager or a one-stop shop sort of centre across ADF-DVA and possibly DCO. I would be grateful for your thoughts on that.

Response:

Defence is currently engaging with the Department of Veterans' Affairs in relation to a number of joint initiatives including the possibility of a single identification number that works across both the Departments of Defence and Veterans' Affairs. The aim of a single ID would be to reduce complexity and resolve proof of identification from the start of a member's service by using an existing numbering system rather than introducing an additional number. This proposal will require further consultation and scoping.

Defence, through Joint Project 2080 Phase 2b.1a, has proposed to implement a 'Single Person ID' and new 'Person Model' within its organisation. This 'Single Person ID' will be integrated into PMKeys and will improve the ability to track individuals through a variety of relationships within Defence, over time. Defence is currently progressing through the design release of this phase of the project.

Defence will continue to consult with the Department of Veterans' Affairs and other relevant stakeholders in relation to the possibility of a single identification number.