Capability through mental fitness

2011 AUSTRALIAN DEFENCE FORCE MENTAL HEALTH AND WELLBEING STRATEGY
The ADF is committed to achieving our vision of capability through mental fitness by:

• promoting good mental health and wellbeing through leadership at all levels

• developing a culture that supports personnel to better recognise mental health issues and assist themselves and their colleagues

• preparing our personnel to meet the unique occupational risks of military service

• evidence-based treatment and recovery programs utilising a partnership between individuals, families, command and health providers

• innovation and research that improves our understanding of mental health and wellbeing in the ADF and delivery of mental health care

• supporting effective transition and continuity of mental health and wellbeing for those personnel leaving the ADF.
MINISTER’S FOREWORD

The Australian Government recognises that mental health and wellbeing has a pivotal role in ensuring we provide the best possible health care for our ADF personnel and their families. The 2011 ADF Mental Health Strategy reflects our ongoing commitment to the wellbeing of our serving men and women. The strategy aims to provide for mental health care for current and future ADF personnel by building on existing reforms and shaping the planning for future services.

Over the last 10 years the ADF has established a strong foundation of mental health, suicide prevention, alcohol awareness and resilience building programs. In 2008, the Government commissioned Professor David Dunt to conduct a review of mental health care in the ADF and transition through discharge. As a result of this review, the ADF received funding for a four-year program of mental health reform to strengthen the services already being provided.

In addition to the expansion and enhancement of the ADF’s mental health workforce, a prevalence study of mental health conditions was prioritised. This study is being used to inform the next evolution of the ADF mental health strategy and shape future mental health programs.

Approximately half of the ADF population was surveyed during 2010, providing the first ever comprehensive profile of mental health and wellbeing of ADF members.

The knowledge gained from the prevalence study has now been combined with developments out of the Dunt Review to inform the 2011 ADF Mental Health Strategy. The strategy ties in to the vision for a whole-of-government approach to mental health reform, as outlined in the Government’s National Mental Health Policy of 2008 and the Fourth National Mental Health Plan 2009–2014.

This strategy is an important milestone in the continuing efforts of the ADF to support its people, and ensures the best quality care with the intention of retaining a highly skilled and professional defence force.

The importance of partnerships and collaboration forms a central pillar of the strategy, giving the ADF options to utilise the latest developments, research and innovation in mental health care. One significant partnership is with the Department of Veterans’ Affairs to ensure the wellbeing of ADF personnel as they return to civilian life.

I acknowledge the key role that commanders, ADF personnel and their families play in addressing the stigma of mental illness by supporting each other and speaking up or seeking help at the earliest opportunity. Ensuring the most effective preventive measures and best quality treatment and rehabilitation for our ADF personnel remains a priority for this Government and no doubt for the ADF itself.

I endorse the 2011 ADF Mental Health Strategy, and commend and thank the ADF and those involved in its development and implementation.

The Hon. Warren Snowdon MP
Minister for Veterans’ Affairs
Minister for Defence Science and Personnel
October 2011
MESSAGE FROM THE CHIEF OF THE DEFENCE FORCE

The ADF is committed to promoting good mental health and recognises that mental fitness is a key component of our overall capability. We must thoroughly prepare our personnel to meet the unique occupational risks of military service. This is achieved by effective leadership at all levels, and the development of a culture that recognises the importance of reducing the stigma of mental illness.

Over the years we have developed a range of valuable foundation programs aimed at improving awareness of mental health issues. This has included equipping our people to recognise the signs of their own distress and that of their colleagues, and knowing where to seek help.

In 2009 we initiated a four-year mental health reform program. We set out on a course to systematically introduce a range of resilience training, and increase our mental health workforce to strengthen our treatment programs. We have taken action to improve literacy and the understanding of post-traumatic stress disorder, suicide prevention and alcohol misuse.

Importantly, we also undertook to gain a better understanding of the mental health needs of ADF personnel to assist in planning future service development. The result of this last initiative is the 2010 Mental Health Prevalence and Wellbeing Study, which has delivered information on the prevalence rates of mental illness in the ADF.

The senior leadership and I are pleased with the progress of mental health reform so far. We see the results of the prevalence study as enhancing our understanding of the mental health needs of our personnel and informing our next steps in the journey toward improving the mental health status of the ADF. In particular, we endorse this 2011 ADF Mental Health Strategy, which outlines the vision, principles and objectives that will guide our future actions.

It is critical that commanders at all levels recognise the importance of good mental health and wellbeing for individuals, and for ADF families, workplaces and capability. The challenge of dealing with mental illness in the ADF is an important one to face, but the benefits to the ADF and wider Australian community are significant.

Our strategy is based on a military occupational mental health approach. This approach recognises that in the unique military environment there is a partnership required for mental health and wellbeing between command, the individual, their family and the health care system. It also recognises that there is much that we can all do to protect and promote wellbeing and resilience in ourselves, our colleagues and our personnel.

Good mental health within the ADF operates on a continuum, starting with a person’s entry into the ADF, their selection, assessment and suitability to the right job, through to preparing them to operate in risky environments. Furthermore, it provides the most effective treatment and rehabilitation if they become ill or injured so they can return to work as soon as possible.
If the person cannot return to work in the ADF, as a last resort we will enable the individual and their family to make the transition to civilian life with the appropriate support in place to maximise their mental health and wellbeing.

Finally, the best resilience and recovery programs cannot be effective if we do not address stigma and break down the barriers that stop individuals seeking care. All ADF personnel need to step forward to improve their awareness of mental health issues, understand ways to maintain good mental health and be willing to seek help or encourage others to do so as early as they can before problems interfere with their family and work life.

D.J. HURLEY, AC, DSC
General
Chief of the Defence Force
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Capability through mental fitness 2011 Australian Defence Force Mental Health and Wellbeing Strategy
BACKGROUND

Strategic development

In 2002, the Department of Defence, in line with the national mental health reform agenda, identified the need to develop a mental health strategy to address service planning for and provision of mental health care. The ADF Mental Health Strategy 2002 integrated the National Mental Health Strategy 1992, as well as the first and second national mental health plans, but also recognised the unique challenges of the Defence environment resulting from the demands of military service.

In 2008, a package of nine ‘Life cycle’ initiatives was introduced by the Government to address mental health issues for ADF personnel that might arise from the time of their recruitment through to their resettlement into civilian life. The package was a joint venture between the Department of Defence, the Department of Veterans’ Affairs and the Australian Centre for Posttraumatic Mental Health. Defence was responsible for the development of three of the initiatives: a longitudinal study of psychological resilience in ADF members, a pilot study of resilience-building initiatives and improving early intervention among and mental health surveillance of serving personnel.

Strategic review

In 2009, the Government commissioned Professor David Dunt to conduct an independent review in order to benchmark current ADF mental health support services against best practice, including the transition process to the Department of Veterans’ Affairs, and to determine the extent to which mental health services met the needs of serving and transitioning ADF personnel.

In his report, Mental Health Care in the ADF and Transition to Discharge, Professor Dunt stated that the introduction of the ADF Mental Health Strategy in 2002 was far-sighted and that some of the programs surpassed similar initiatives in other Australian workplaces and international military forces. Nevertheless, the review highlighted gaps in the delivery of mental health services in Defence. He made 52 recommendations to reform and enhance ADF mental health programs, as well as the transition services of both Defence and the Department of Veterans’ Affairs.

Defence is implementing the recommendations of the Dunt Review through a comprehensive four-year mental health reform program, which started in July 2009. Already nearly half of the recommendations have been implemented, including completion of the 2010 Mental Health Prevalence and Wellbeing Study and the development of this, the next generation of the ADF mental health strategy.
Strategic refinement

The goals of the ADF Mental Health Reform Program have been refined and aligned with the Fourth National Mental Health Plan (2009–2014) to form the 2011 ADF Mental Health and Wellbeing Strategy. The strategy’s focus is similar to that of the Fourth National Mental Health Plan in that it takes a whole-of-government approach, with a particular emphasis on partnering with the Department of Veterans’ Affairs to ensure more effective transition, when required, for ADF personnel. Figure 1 shows the evolution of mental health reform in the ADF over the last 10 years and how it will evolve into the future.

Defence will now develop the 2012–2015 Mental Health and Wellbeing Action Plan. This plan will ensure the progression of the Dunt Review recommendations by mid 2013, but will also maintain the momentum of the Mental Health Reform Program, to ensure that the ADF has in place a system that is self-monitoring and continuously improving.
Figure 1: Evolution of mental health reform in the ADF

2002 ADF Mental Health Strategy

2004 Dunt Review

2006 Life cycle initiatives

2008 Mental health reform

2010 2012–15 Action Plan

2011 Strategy

2014

2002

2004

2006

2008

2010

2012

2014

SUICIDE PREVENTION PROGRAM (Standardised awareness, KYMS—suicide prevention, and ASIST training)

Critical incident mental health support

Resilience building program

Alcohol, tobacco & other drugs program

Integration and enhancement of mental health services

Mental health research & surveillance

Establishment of regional mental health networks

Promotional material to improve mental health literacy

Policy development

Standardised annual awareness training

Mental health website

Health provider upskilling (Traumatic Stress Syndromes course)

Standardised return to Australia and post-operational screening processes

Suicide prevention program

Critical incident mental health support

Resilience building program

Alcohol, tobacco & other drugs program

Integration and enhancement of mental health services

Mental health research & surveillance

Establishment of regional mental health networks

Promotional material to improve mental health literacy

Policy development

Standardised annual awareness training

Mental health website

Health provider upskilling (Traumatic Stress Syndromes course)

Sample text

Note:

ATOD Alcohol, Tobacco and Other Drugs

CBT Cognitive behavioural therapy

Laser Longitudinal ADF Study Examining Retention and Resilience

PTSD post-traumatic stress disorder

SMART self-management and resilience training

SPP Suicide Prevention Program

Capability through mental fitness 2011 Australian Defence Force Mental Health and Wellbeing Strategy
Prevalence of mental disorders

The estimated prevalence of mental disorder in the ADF over a 12-month period is of the same magnitude as that of the general community and therefore has the potential to have a substantial impact on individual wellbeing and operational capability.

Results from the Mental Health Prevalence and Wellbeing Study indicate that one in five of the ADF population had experienced a mental disorder in the previous 12 months, which is a similar rate to that in a sample matched for age, sex and employed from the 2007 National Survey of Mental Health and Wellbeing conducted by the Australian Bureau of Statistics (ABS). More than half of the ADF has experienced an anxiety, affective or alcohol disorder at some stage in their lifetime, which is significantly higher than the matched Australian community rate.

The largest deviation from the Australian community was among males in the ADF, who had a significantly greater prevalence of affective disorders and a significantly lower prevalence of alcohol disorders. The mental health of ADF females did not differ significantly from that of females in the Australian community, except that ADF females had a lower prevalence of alcohol disorders.

A challenge for the broader community is the incidence of mental disorder among youth. An examination of the interrelationship between age and each of the mental disorder groups revealed that, as in the general population, mental illness in the ADF is most common in the 18 to 37 age range.

An estimated 11,016 ADF members met diagnostic criteria for a mental disorder in the last 12 months. Of these, 7,420 had an anxiety disorder, 4,757 had an affective disorder, and 2,590 had an alcohol disorder. While the overall 12-month mental disorder rates in the ADF were similar to those in the Australian community study, there is a significant difference in the profile of mental disorders.

Figure 2: ADF compared to a matched Australian community sample for mental disorders, by sex (ADF and ABS data)
Anxiety disorders

The most common mental disorder in the ADF is anxiety disorder; the prevalence rate is not significantly different to that of the Australian community. The most prevalent of the anxiety disorders in the ADF is post-traumatic stress disorder, which was significantly more prevalent than in the matched community sample. This was not unexpected considering the types of occupational risks in the military.

Affective disorders

ADF personnel, particularly males, experience a significantly higher rate of affective disorders when compared with the Australian community. Of the affective disorders, the most prevalent was depressive episodes, where the rate was significantly higher than in the Australian community, especially in the younger age groups. Within the community, depression is typically more prevalent in middle age. It may be that the occupational stressors (such as deployment experiences and absence from family and support networks) of military service result in earlier onset of these disorders.

Alcohol disorders

The self-report data from the study showed high levels of general use, consistent with community rates, but this is not translating to disorder in the ADF population. Alcohol disorders were significantly lower in the ADF than in the general community, with most of the disorder in males in the 18–27 age group. There was no difference between the Services on alcohol dependence disorder. Personnel in the Navy and Army, however, were significantly more likely than Air Force personnel to have alcohol harmful use disorder.

Suicidality

The prevalence of suicidal ideation and making a suicide plan was significantly higher in the ADF compared to the community. However, the number of attempts was the same, although the number of deaths was lower than in the general community. These findings suggest that the comprehensive initiatives on literacy and suicide prevention currently being implemented in the ADF may be having a positive impact. That is, although ADF personnel are more symptomatic and more likely to express suicidal ideation than people in the community, they are only as likely to attempt suicide and less likely to complete the act. The current evaluation of the ADF Suicide Prevention Program will provide insight into what is effective.

Impact of deployment

Among ADF personnel, an estimated 43% reported having been deployed multiple times, 19% reported having been deployed only once, and the remaining 39% of personnel have never been deployed. Army has the highest incidence of multiple deployments at 46%, followed by Navy with 41%. Air Force has the lowest frequency of multiple deployments at 36%. Navy, at 11%, has the highest proportion of personnel reporting six or more deployments.

There was very little difference for mental disorder in the previous 12 months between personnel who have been on deployment and those who have never been deployed. This result suggests that the significant resources invested by the ADF in a comprehensive operational mental health support system may be effective in the prevention of and early intervention for mental disorder resulting from exposure to occupational stressors associated with operations. This proposition is supported by the fact that personnel who have been deployed are more likely to seek care than personnel who have never been deployed.
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, it is likely that – consistent with international literature – the number of deployments is not as predictive as the level of trauma or combat exposure for the level of negative mental health outcomes.

**Help seeking**

Almost one in five personnel (17.9%) reported that they had sought help for a stress-related, emotional, mental health or family problem in the previous 12 months. However, only half the sample with post-traumatic stress disorder or depressive episodes reported receiving treatment in the previous 12 months and only 15% of those with alcohol dependence disorder.

The highest rated barrier to seeking help was concern that it would reduce deployability (36.9%). The most frequently perceived stigma for ADF personnel was that people would treat them differently if they sought care (27.6%) and that seeking care would harm their career (26.9%).

**Impact on workforce**

ADF personnel reported significantly more partial, rather than total, days out of role due to psychological distress than the Australian community. The data indicate that mental disorder has an impact on the ability of personnel to work, not only in terms of absenteeism but also in the number of days where they are unable to fully and adequately perform while at work. Individuals with affective disorders, for example, report an average of 23 days off in a year due to the disorder. This loss not only reduces the member’s wellbeing but creates a significant drain on the capability and resources of the ADF.

The total days out of role in the previous four weeks in the ADF were equally accounted for by depressive (41.1%) and anxiety (42.9%) disorders and were higher than the burden for any alcohol disorder (7.1%). The highest ranked disorders were panic attack (32.7%), depressive episodes (32.4%), specific phobia (28.4%) and post-traumatic stress disorder (24%).

When any mental disorder is considered, 61.8% of the total days ADF members were unable to work due to psychological distress are attributable to a definable psychiatric disorder. Significantly, the remaining figure (38.2%) represents days out of role for non-specific symptomatology. This proportion highlights the importance of acute distress in the absence of a diagnosis as a source of disability as well as diagnosable disorders. Further work will also be done to determine the economic cost to Defence and impact on readiness and capability of mental disorder.
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 based on the Military Occupational Mental Health and Wellbeing Model (see Figure 3). The model provides a framework for the development of interventions to enhance the mental health and wellbeing of ADF personnel. These interventions need to take into account the environment, culture, social support networks and impact of families. Furthermore, the model 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.

Figure 3: ADF Military Occupational Mental Health and Wellbeing Model
This joint approach allows the development of interventions in five key areas:

**Foundation strengths** – ADF personnel require foundation strengths to meet the challenges of military service. Interventions to ensure that ADF personnel have those strengths include effective selection strategies, comprehensive training to develop confidence in occupational skills and knowledge, a command climate that builds cohesive and effective leadership behaviours, and training to build resilience and strengthen coping skills.

**Risk reduction** – Effective interventions need to be in place to identify risks, monitor their impact and facilitate risk mitigation strategies. These interventions include using trained peers who are literate in mental health and can identify and assist ‘mates’ requiring assistance through a comprehensive e-health surveillance system, and initiatives to educate command about the potential impact that unit climate can have on unit morale and individual wellbeing.

**Early intervention** – For individuals exposed to high risk, early intervention strategies are needed for the individual, command and health care personnel. These include:

- ensuring personnel are trained in mental health first aid
- using mental health screening programs to identify individuals for referral and issues and trends for command
- increasing awareness and use of unit climate and human resources to identify leadership factors that contribute to unit and individual wellbeing, effectiveness and morale
- using ceremonies and activities that promote mental health and wellbeing, as well as personal satisfaction (including recognition of unit and personal achievement)
- ensuring evidenced-based psycho-education is available.

**Treatment** – Some individuals will suffer injuries or illness and require access to evidence-based treatment and rehabilitation programs that focus on returning to work. Where this is not possible, these individuals may need support through the transition process into either alternative ADF occupations or civilian life. These programs and systems must be responsive to command and the individual member and support engagement of family and support networks in the recovery process.

**Transition** – Recognition of their service and a seamless transition to civilian life is important for all ADF personnel. Transition services should begin well before final transition and should continue for a period beyond discharge. It is important that these services provide information to ADF personnel on the full range of services, resources and benefits available to them. ADF personnel with chronic mental illness who are making the transition out of the ADF need comprehensive support.
IMPLEMENTING THE 2011 STRATEGY

Introduction

Good mental health and resilience are fundamental to the wellbeing of ADF personnel. Wellbeing is important to physical health and personal and work relationships. It is also important to achieving individual and organisational potential. Mental health is crucial for ADF personnel to be able to function effectively in their personal and professional lives, particularly when dealing with stressful events associated with operational deployments.

While Defence acknowledges its role in promoting mental health, we all need to take responsibility for caring for our own mental health and that of others and we need to challenge the stigma associated with mental disorder in the ADF.

The 2011 Australian Defence Force Mental Health and Wellbeing Strategy builds on the 2002 ADF Mental Health Strategy and provides a framework for the development and implementation of mental health and occupational psychology policy, programs and services for the ADF.

Through the development, implementation and evaluation of initiatives that holistically target ADF personnel, their families, commanders and the health workforce, the ADF will ensure a strong foundation of good mental health and wellbeing. By promoting mental health and intervening early, we can help prevent mental disorder from developing and mitigate and manage its effects when it does.

Strategic partnerships and key stakeholders

Figure 4 shows the relationships that will be strengthened through the 2011 ADF Mental Health and Wellbeing Strategy. These linkages and partnerships help to ensure that the Mental Health Reform Program remains consistent with the national reform agenda and Defence is able to leverage national advances. An enhanced relationship with the Department of Veterans’ Affairs, in particular, will ensure that both serving and transitioning veterans are provided with more seamless care.
Structure of mental health service delivery in the ADF

Joint Health Command, through Garrison Health Operations, and with augmentation from the single Services, provides comprehensive and integrated mental health and occupational psychology services to the ADF. The mental health and psychology services delivery model provides multidisciplinary mental health and occupational psychology services that are fully integrated with the primary health care system. In addition, each of the single Services generates mental health and psychology capability for deployed environments.

Through the ADF Mental Health and Wellbeing Action Plan 2012–2015, Joint Health Command will continue to discuss with each of the Services how and what mental health and psychology services are delivered to the ADF.
Technical authority responsibilities

The Director General, Mental Health, Psychology and Rehabilitation is accountable to the Surgeon General Australian Defence Force for the technical authority for the provision of strategic direction and governance of the systems, policies and procedures for mental health, psychology and rehabilitation for ADF personnel.

The Director General is responsible for the development and evaluation of:

- clinical and governance frameworks
- standards of care
- training of health care personnel
- policies, procedures and programs of care related to mental health, psychology and rehabilitation.

Governance

The 2011 ADF Mental Health and Wellbeing Strategy is underpinned by the Fourth National Mental Health Plan, the National Standards for Mental Health Service 2010, and the National Practice Standards for the Mental Health Workforce 2002.

The Mental Health Advisory Group, which was established in August 2011, provides strategic and practical advice to identify solutions that will improve the mental health and wellbeing of ADF personnel and their families. Its members draw on their knowledge and experience in mental health service development, clinical practice, research and the requirements of the military occupational environment.

The Mental Health and Wellbeing Implementation Working Group facilitates the development of the Action Plan 2012–15 and the implementation of policy and programs within each of the single Services.
STRATEGIC OBJECTIVES AND OUTCOMES

Strategic Objective 1:
Promote and support mental fitness within the ADF

Strategic Objective 2:
Identification and response to mental health risks of military service

Strategic Objective 3:
Delivery of comprehensive, coordinated, customised mental health care

Strategic Objective 4:
Continuously improve the quality of mental health care

Strategic Objective 5:
Building an evidence base about military mental health and wellbeing

Strategic Objective 6:
Strengthening strategic partnerships and strategic development

Capability through mental fitness 2011 Australian Defence Force Mental Health and Wellbeing Strategy
Strategic Objective 1:  
Promote and support mental fitness within the ADF

Outcomes

A culture that promotes wellbeing and reduces the stigma and barriers to mental health care.

ADF personnel are mental health literate and know when, how and where to seek care for themselves and their peers.

Selection, training and command systems that promote good mental health and wellbeing.

Table 1: Proposed comprehensive mental health literacy and resilience training continuum

<table>
<thead>
<tr>
<th>Training continuum</th>
<th>Program</th>
<th>Content</th>
<th>Non-commissioned officers and other ranks</th>
<th>Officers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Resilience</td>
<td>SMART</td>
<td>Including Suicide Prevention Program</td>
<td>Recruit</td>
<td>-</td>
</tr>
<tr>
<td>Mental Health Peer Support</td>
<td>KYMS – Peer Support</td>
<td>KYMS–Suicide Prevention Program, KYMS–Alcohol Tobacco and Other Drugs, BattleSMART, Critical Incident Mental Health Support, Mental health first aid</td>
<td>Initial employment training</td>
<td>Ab initio training</td>
</tr>
<tr>
<td>Mental Health Leader</td>
<td>KYMS – Leader</td>
<td>Resilience &amp; mental health leadership in mental health, BattleSMART coaching, Early detection, Mental health first aid, Promoting prevention programs</td>
<td>Junior soldiers/sailors/airmen &amp; airwomen</td>
<td>Ab initio training</td>
</tr>
<tr>
<td>Mental Health Mentor</td>
<td>KYMS – Mentor</td>
<td>Understanding health systems, Understanding mental health treatment, Needs assessment, Understanding care planning, Problem solving, Communication, Self-care</td>
<td>Senior soldiers/sailors/airmen &amp; airwomen</td>
<td>Junior officers</td>
</tr>
</tbody>
</table>

Deployment Resilience: Pre- & post-deployment BattleSMART

Transition Resilience: LifeSMART

Continuous training:
- KYMS-Suicide Prevention Program
- KYMS–Alcohol Tobacco and Other Drugs
- Post-traumatic stress disorder DVD
- Applied Suicide Intervention Skills Program
- Annual mental health awareness
ADF personnel are often the first to notice that a mate needs assistance and need to encourage those suffering mental health problems to seek help early. Improved mental health literacy in the ADF will ensure that all personnel can identify and assist with mental illness in themselves and their mates.

Keep Your Mates Safe – Peer Support (KYMS–PS) has been developed to provide ADF personnel with a high level of mental health in the first year of their service. It covers a range of mental health topics, including:

- mental health first aid
- safe consumption of alcohol
- suicide prevention
- critical incident mental health support
- resilience training.

KYMS–PS was piloted with trainees at the Army Logistic Training Centre in early 2011 and was well received.

Development of KYMS–Leader and KYMS–Mentor courses is now under way. The KYMS–Leader course will target junior leaders, both other ranks and officers. It will cover the skills needed by leaders – creating a positive command environment, group resilience, understanding the mental health risks associated with military service and mental health first aid.

The KYMS–Mentor course will target senior enlisted personnel and officers, and will include reinforcing leadership behaviour that promotes good mental health, an overview of the ADF Medical Employment Classification system, and the rehabilitation and welfare board systems. It will also include an introduction to assessment and treatment options for mental health problems, problem solving, communications strategies and self-care.
Strategic Objective 2: Identification and response to mental health risks of military service

Outcomes

A mental health and psychological support continuum that maximises the resilience of ADF personnel so they can adapt to all aspects of military service.

Mitigation of deployment risks and effective transition back to work and family life.

Figure 5: The operational mental health support continuum

Note:
CIMHS  Critical Incident Mental Health Support
POPS  Post-operational Psychological Screening
RIAPS  Return to Australia Psychological Screening
SMART  self-management and resilience training
ADF personnel who are deployed receive 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.

Before deployment to an operational theatre, ADF personnel receive psycho-educational training tailored to the potential risks they will face. Pre-deployment psychological preparation covers topics such as separation, cultural adaptation, operational tempo, fatigue and stress management, and homecoming.

If ADF personnel are exposed to a critical incident or potentially traumatic events, commanders can activate a critical incident mental health support (CIMHS) response.

Groups who are engaged in high-risk activities for extended periods (such as search engineers or human intelligence analysts) may be offered additional psycho-education and a special psychological screen mid-deployment.

ADF personnel receive psychological screening when they leave the area of operations and post-operational screening three to six months after they return to Australia. Both processes include a screening questionnaire and an individual interview. The screenings provide individualised psycho-education, early identification of at-risk individuals, and surveillance to capture information used by command to assist in operational transition and to identify trends for incorporation into future deployment preparation.

Work is under way to enhance the post-operational transition process, including trials of third location decompression, leadership coaching in the reintegration period and a structured readjustment and wellbeing period at three to six months after deployment. A trial is being conducted in which interested spouses or family members participate in a component of the Post Operational Psychological Screening (POPS) process.
Strategic Objective 3:
Delivery of comprehensive, coordinated, customised mental health care

Outcomes
A holistic mental health and psychology service that integrates with the primary health care system and a stepped care approach with multiple pathways to care.

Care is coordinated with individuals, families, command and health services.

Innovative approaches to technology support systems that support the delivery of mental health care.

Figure 6: Pyramid of mental health and psychological services*

* Based on a figure that depicts an optimal mix of services for mental health in World Health Organization 2009, Improving health systems and services for mental health (Mental health policy and service guidance package).

Note:
- AREP: Alcohol Rehabilitation and Education Program
- ASIST: Applied Suicide Intervention Skills Training
- CHRP: Coming Home Readjustment Program
- CIMHS: Critical Incident Mental Health Support
- KYMS: Keep Your Mates Safe
- MHPS: Mental Health and Psychology Section
- OATP: Outpatient Alcohol Treatment Program
- POPS: Post Operational Psychological Screening
- PULSE: Profile of Unit Leadership, Satisfaction and Effectiveness
- SMART: Self-management and resilience training
- VVCS: Veterans and Veterans Families Counselling Service

Self-care – most people manage their mental health themselves, or with support from family and friends. Self-care is most effective when it is supported by formal health services.
A fundamental component of the 2002 ADF Mental Health Strategy, which has continued to evolve, is the ADF Suicide Prevention Program. This program includes a range of suicide awareness and prevention training sessions for ADF members and health service providers.

Since the Suicide Prevention Program started, leadership and command at all levels have provided significant support to address the issue of suicide and the proactive management of individuals at risk. As part of the Suicide Prevention Program, policy on the management of ADF personnel who are at risk of suicide has been developed, and clinical guidelines for health service providers are continuously reviewed and enhanced.

Joint Health Command continues to monitor trends and has supported a comprehensive study of protective and risk factors. Based on lessons learnt, the ADF developed and delivered a suite of suicide prevention training, including an online option.

The enhanced mental health workforce and the establishment of eight regional mental health teams are significantly improving the ability of the ADF to roll out further suicide prevention initiatives and training for health care providers.

The new ADF service delivery model will ensure enhanced pathways to care and standardised suicide risk assessment for potentially at-risk individuals. This holistic approach to care will ensure access to the most suitable mental health service providers, effective case management throughout the treatment process and effective engagement with families and support systems.

Suicide rates in the ADF have declined since the implementation of focused mental health and suicide prevention strategies in 2002. The ADF Mental Health Prevalence data suggest that, while ADF personnel do have high rates of ideation, this does not translate into high rates of suicide. This suggests that the program is having a positive impact. To investigate this fully, the Australian Institute for Suicide Research and Prevention at Griffith University is working with Defence to evaluate the effectiveness of the ADF Suicide Prevention Program.
Strategic Objective 4: Continuously improve the quality of mental health care

Outcomes

A governance framework that promotes the delivery of safe, efficient, effective and appropriate mental health care.

A workforce that is trained and equipped to provide evidence-based clinical practice that supports recovery.

Figure 7: Improving the quality of mental health care
Encouraging the responsible use of alcohol within the ADF is a high priority of the ADF’s mental health reform program. The ADF Alcohol, Tobacco and Other Drugs Program aims to establish evidence-based programs and identify strategies to sustain long-term cultural change around alcohol in the ADF.

Recently, the Alcohol, Tobacco and Other Drugs Program developed an ADF Alcohol Management Strategy in response to concerns raised in 2009 by the Chief of Army about the number of alcohol-related incidents.

Defence engaged the Australian Drug Foundation to help develop the Alcohol Management Strategy, in a tri-service initiative led by Joint Health Command. The ADF Alcohol Management Strategy aims to construct an evidence-based strategy that builds the ADF’s capacity to effectively manage alcohol, enhance capability, reduce personal harm and minimise organisational costs.

Extensive consultation has occurred to gather the evidence to better understand alcohol attitudes, behaviour, education, training, policy and culture within the ADF. The consultations took place across a range of Defence locations and included leadership teams, officers, soldiers, sailors and airmen and community groups. Reviews of ADF policy and literature are being undertaken to enable benchmarking against community, workplaces and the military forces of other countries.

Interim reports have been presented and accepted by the senior leadership in Defence. A final report on the ADF Alcohol Management Strategy will be provided in November 2011, and implementation is planned for 2012.
Strategic Objective 5:
Building an evidence base about military mental health and wellbeing

Outcomes
A rigorous research program that is priority driven and addresses key knowledge gaps.
A range of mental health programs providing positive outcomes and services that have been fully evaluated.

Within SMART training, individuals are taught to ‘test’ their initial reactions in four domains – physical, thoughts, emotion and behaviour – and to ‘adjust’ if the initial response is unhelpful, or is not going to achieve optimal performance. The skill of being able to ‘test’ and ‘adjust’ is fundamental to the SMART program. The aim of the program is not just to enhance individual mental health and resilience; it extends to the realisation of optimal performance for the individual and the team.
SELF-MANAGEMENT AND RESILIENCE TRAINING – SMART

The ADF is introducing a comprehensive continuum of self-management and resilience training, or the SMART program. The program builds on and enhances individual and group coping strategies to deal with the challenges of military service, both in Australia and while on deployment. Strategies for coping are taught in four central domains, including adaptive behaviour, adaptive ways of thinking about the situation, managing physiological responses and emotional regulation.

As part of the training, individuals are taught to test their initial responses in these four domains and to adjust if the initial response is unhelpful, or is not going to achieve optimal performance. The skill of being able to test and adjust is fundamental to the SMART program. The aim of the program is not just to enhance individual mental health and resilience but also to realise optimal performance for the individual and the team.

SMART modules are being developed for certain points in the life cycle of ADF personnel that have been identified as particularly challenging. These points include preparing personnel for the realities of recruit training, deployment, high-risk employment and transition out of the services.

- **Recruit BattleSMART** was first introduced at the Army Recruit Training Centre in July 2009, and will be implemented at all ADF ab initio training establishments for both other ranks and officers by 2012.

- **Deployment BattleSMART** programs have been trialled as part of pre- and post-deployment preparations for mentoring taskforces being deployed to Afghanistan.

- **Peer BattleSMART** is a module that focuses on helping peers and has been developed as a part of the Keep Your Mates Safe – Peer Support program.

- **LifeSMART** aims to assist personnel transitioning from the ADF.

- **FamilySMART** is an awareness package developed by the Defence Community organisation for ADF families.

A significant future enhancement will make interactive BattleSMART modules and materials available on the internet to target individuals who are not being deployed as part of formed units. Internet access to the materials will allow ADF personnel to refresh their earlier learning in times of need and enable family members to access SMART materials.

Ongoing evaluation of the BattleSMART program is a priority. The program has been enhanced by international collaboration with military health services personnel from the United States, the United Kingdom, Canada and New Zealand. This ongoing evaluation will help to shape the direction of the program for the ADF.

The effectiveness of the program is also being monitored and enhanced through Project LASER (Longitudinal ADF Study Examining Resilience).
Strategic Objective 6:
Strengthening strategic partnerships and strategic development

Outcomes
Whole-of-government partnerships.
Partnerships with centres of excellence.
Partnerships with international military forces.

Figure 8: LASER–Resilience time points

The LASER–Resilience project, which is an example of a strategic research partnership, is a longitudinal survey of newly appointed ADF personnel. The sample consists of approximately half the general entry population and all officer recruits.

Defence is particularly interested in improving understanding of factors that predict mental fitness. The project aims to examine the processes and mechanisms associated with healthy adjustment to conditions of the military, and to identify risk and protective factors to minimise the impact of occupational stressors.
The ADF has had a long-term strategic partnership with the Australian Centre for Posttraumatic Mental Health at the University of Melbourne. The centre has had a major role assisting Defence in the development of the ADF Operational Mental Health Screening Program, the Critical Incident Mental Health Support Program and key mental health policies and research projects. Recently the centre conducted mental health case management training nationally for the ADF health workforce; it also delivers the Traumatic Stress Syndromes Course.

The current major research collaboration between the centre and Defence is the resilience component of the Longitudinal ADF Study Examining Retention and Resilience (LASER–Resilience or LASER–R). This study is investigating the psychological mechanisms that underpin resilience in the ADF. The LASER–Resilience project involves a series of five data collection points: at enlistment, at the end of initial training, and through annual surveys for the following three years.

The study aims to improve understanding of psychological resilience in ADF personnel, and to identify the characteristics that are likely to assist individuals to cope with the wide range of experiences they will encounter in military service. The results will be used to inform and shape mental health services and as well as to enhance the self management and resilience training (SMART) program.

Data collection for LASER–R began in November 2009 and will continue until the end of 2012. The first annual report describing cross-sectional trends emerging from the data collected will be complete by the end of 2011. From 2012, longitudinal data analysis will commence; the annual reports will then include the discussion of trends and changes over time.
PRIORITY ACTIONS

Addressing stigma and barriers to care
Enhancing service delivery
Developing e-mental health approaches
Upskilling health providers
Improving pathways to care
Strengthening the mental health screening continuum
Developing a comprehensive peer support network
Defence is now developing the Mental Health and Wellbeing Action Plan 2012–2015. This plan will finalise implementation of the Dunt Review recommendations and achieve the strategic objectives of the ADF Mental Health and Wellbeing Strategy. The findings of the ADF Mental Health Prevalence and Wellbeing Study have highlighted some initiatives that warrant immediate attention. These seven priorities are outlined below.

**Addressing stigma and barriers to care**

The study identified a difference between the ranks in terms of stigma and barriers to seeking care – with junior personnel more likely to perceive organisational barriers to seeking care and officers to perceive stigma about mental illness. These findings suggest that a comprehensive communications strategy with specific messages targeting these populations is required.

**Enhancing service delivery**

The rate of mental health prevalence in the ADF requires Defence to continue to give priority to strengthening the provision of mental health care. Joint Health Command will complete the roll out of the stepped care model of service delivery (including surveillance through mental health screening by health providers, guided self-help through greater use of e-mental health technology, face-to-face briefings and longer-term interventions and treatment). This approach is integrated with primary health care and includes mental health and psychology sections, the regional mental health teams and the ADF Centre for Mental Health.

**Developing e-mental health approaches**

The study highlighted specific mental health needs among the young adult ADF population. Defence will utilise and adapt approaches being developed in the broader community to address similar concerns and implement a program of e-mental health solutions tailored to meet the specific needs and expectations of this group. The approach should address issues of stigma and barriers to care and allow personnel and their families to access online information, advice and treatment when and where they feel comfortable and in a medium with which they are familiar.

**Upskilling health providers**

All Defence health providers need to have the skills to deal with mental health problems and illness. The plan will provide for all health providers to complete mandatory training in risk assessments, systematic diagnostic assessment, case formulation and brief intervention.

**Improving pathways to care**

The study has identified a cohort of personnel with mental illness. A specific research program can now be undertaken with ADF personnel who have consented to be contacted to determine if they have accessed or need care and, if still symptomatic, will accept a referral. The outcome of such research will, importantly, encourage those ADF personnel to undertake mental health care and identify potential barriers to care and preferred treatment options.
Strengthening the mental health screening continuum

Screening provides an opportunity for early and one-off brief interventions. The ADF conducts mental health screening in the periodic health assessment and the deployment cycle. To ensure that personnel who are not deploying are regularly assessed, it is proposed that an annual mental health screen be introduced. This would only be administered to personnel who had not been through one of the other screening processes in the previous twelve months. The screening process will be developed as a component of the Joint e-Health Data and Information (JeDHI) system.

Developing a comprehensive peer support network

ADF personnel are often the first to notice that a mate needs assistance. Encouraging those suffering mental health problems to seek assistance early should help in reducing the prevalence of mental illness. Increasing the mental health literacy of ADF personnel will make them more likely to identify the signs of illness in themselves and others and encourage them to seek treatment. To develop a workforce that is literate in mental health, Defence is developing a comprehensive Keep Your Mates Safe mental health network that includes peers, leaders, mentors and trainers. The program includes identification of mental health problems, mental health first aid, safe alcohol use, and suicide, BattleSMART (Self Management and Resilience Training) and Critical Incident Mental Health Support.