Primary health care in the ADF

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An earlier article by the author asserted that high rates of preventable workplace illness and injury indicate the need to improve the management of the occupational and environmental hazards associated with ADF workplaces, with emphasis on prevention rather than treatment.[1] This article expands with respect to providing primary health care for ADF members.

Primary health care in Australia

In 2014, the Australian health care system had 98,807 medical practitioners in more than 80 specialties, including 32,050 general practitioners.[2] The latter included 21,576 Fellows and trainees of the Royal Australian College of General Practitioners, and 1630 Fellows and trainees of the Australian College of Rural and Remote Medicine. The remaining 8844 general practitioners did not have fellowships but were vocationally registered by Medicare to provide primary health care services. By comparison, in 2014 the Australasian Faculty of Occupational and Environmental Medicine represented only 492 Australian physicians and trainees.

Definitions

The definitions of 'primary health care' used in Australia are rather complex. The Australian Institute of Health and Welfare defines primary health care as 'typically the first health service visited by patients with a health concern…. It includes most health services not provided by hospitals, and involves:

- A range of activities, such as health promotion, prevention, early intervention, treatment of acute conditions and management of chronic conditions;

- Various health professionals, such as general practitioners, dentists, nurses, Aboriginal health workers, local pharmacists and other allied health professionals; and

- Services delivered in numerous settings, such as general practices, community health centres, allied health practices including physiotherapy and dietetic practices, and more recently via telecommunications technologies such as health advice telephone services, video consultations and remote monitoring of health metrics through electronic devices'.[3]

The College of Rural and Remote Medicine's position paper, 'Defining the specialty of general practice', refers to the 1991 international consensus description of general practice as follows:

> The general practitioner or family physician is the physician who is primarily responsible for providing comprehensive care to every individual seeking medical care and arranging for other health personnel to provide services when necessary.
>
> The general practitioner/family physician functions as a generalist who accepts everyone seeking care, whereas other health providers limit access to their services on the basis of age, sex or diagnosis. The general practitioner/family physician cares for the individual in the context of the family, and the family in the context of the community, irrespective of race, religion, culture or social class. He is clinically competent to provide the greater part of their care after taking into account their cultural, socio-economic and psychological background. In addition, he takes personal responsibility for providing comprehensive and continuing care for his patients.
>
> The general practitioner/family physician exercises his/her professional role by providing care, either directly or through the services of others according to their health needs and resources available within the community he/she serves.[4]

The Royal Australian College of General Practitioners' website describes general practice as providing 'person-centred, continuing, comprehensive and coordinated whole person health care to individuals and families in their communities'.[5] It also indicates that, as a relationship-based specialist medical discipline, general practitioner clinicians are defined by the characteristics of their discipline, which are person-centredness; continuity of care; comprehensiveness; whole person care; diagnostic and therapeutic skill; coordination and clinical teamwork; continuing quality improvement; professional, clinical and ethical standards; leadership, advocacy and equity; and continuing evolution of the discipline.

Implications

Some general practice attributes, per the Royal Australian College of General Practitioners' website in particular, facilitate the baseline clinical skills required to provide primary care for deployed ADF members and to undertake humanitarian aid/disaster-relief operations.[6] These attributes include providing comprehensive whole-person diagnostic and therapeutic care to individual patients within a clinical, multi-disciplinary environment (usually but not always in a lead role).

However, the attributes that are less consistent with respect to primary care for ADF members pertain to person-centredness (particularly with respect to the duty-of-care obligations of their patient's chain of command), continuity of care (with particular reference to their patient's geographic mobility) and primarily providing care for a working-age population that has an increasing but still small proportion of female members.[7]

Furthermore, neither the College of Rural and Remote Medicine nor the Royal Australian College of General Practitioners refers to a role for general practitioners with respect to assessing the effects of workplace hazards on their patient's health or vice versa (that is, assessing their patient's medical suitability for employment). The author's earlier paper described some of the limitations of general practitioners regarding their capacity to undertake these tasks.

On the other hand, military and civilian occupational and environmental physicians can complement their general practitioner colleagues regarding the primary care diagnosis and treatment of workplace-related musculoskeletal and mental health disorders, managing workplace-based rehabilitation, and assessing medical suitability for employment and deployment.

Reasons for presentation	Number	%	Rate per 100,000	5% LCL[b]	95% UCL[c]
Prescription[a]	13,131	8.7	13.3	12.6	14.0
Checkup[a]	13,015	8.6	13.2	12.6	13.8
Test results[a]	9342	6.2	9.5	9.0	9.9
Cough[c]	6187	4.1	6.3	5.8	6.7
Back complaint[a,c]	3347	2.2	3.4	3.2	3.6
Vaccinations[a,d]	3324	2.2	3.4	3.1	3.6
Administration procedure[a]	3252	2.1	3.3	3.1	3.5
Throat complaint[c]	2836	1.9	2.9	2.6	3.1
Rash[a]	2678	1.8	2.7	2.5	2.9
Blood test[a]	2283	1.5	2.3	2.2	2.5
Depression[c,d]	2224	1.5	2.3	2.1	2.4
Abdominal pain[a]	2101	1.4	2.1	2.0	2.3
Upper respiratory tract infection[c,d]	2077	1.4	2.1	1.8	2.4
Fever	1826	1.2	1.8	1.7	2.0
Headache[a]	1635	1.1	1.7	1.5	1.8
Skin complaint[c]	1577	1.0	1.6	1.5	1.7
Hypertension/high blood pressure[a,d]	1505	1.0	1.5	1.3	1.7
Knee complaint[c]	1505	1.0	1.5	1.4	1.6
Observation/education/advice/diet[a]	1499	1.0	1.5	1.4	1.7
Anxiety[a,c]	1465	1.0	1.5	1.4	1.6
Weakness/tiredness	1464	1.0	1.5	1.4	1.6
Other referrals not elsewhere classified	1458	1.0	1.5	1.4	1.6
Sneezing/nasal congestion[c]	1281	0.8	1.3	1.1	1.5
Shoulder complaint[c]	1259	0.8	1.3	1.2	1.4
Diabetes[a,d]	1251	0.8	1.3	1.1	1.4
Diarrhoea	1238	0.8	1.3	1.1	1.3
Ear pain/earache	1220	0.8	1.2	1.1	1.3
Sleep disturbance	1162	0.8	1.2	1.1	1.3
Vertigo/dizziness	1086	0.7	1.1	1.0	1.2
Foot/toe complaint[c]	1086	0.7	1.1	1.0	1.2
Subtotal	**89,287**	**58.9**	**-**	**-**	**-**
Total Reasons for Presentation	**151,636**	**100.0**	**153.6**	**151.8**	**155.4**

Table 1: Top 30 reasons to present to civilian general practitioners, 2013-148

ADF non-deployed primary health care

The earlier paper noted that, anecdotally, only 20-40 per cent of ADF primary care presentations are for conditions typically seen in an equivalent Australian civilian population. In support of this contention, Table 1 describes the top 30 reasons for civilian patients to see a general practitioner in 2013-14.

Notes:

a. Includes multiple diagnoses.

b. LCL = lower confidence level; UCL = upper confidence level. The smaller the interval between LCL and UCL, the more likely the rate per 100,000 presentations figure is truly representative.

c. Most common ADF clinical conditions in 2007-8 and 2008-9.[9]

d. Most common civilian clinical conditions.[10]

Furthermore, Table 2 shows that in 2013-14, only 2.4 per 100 patient presentations to civilian general practitioners were for work-related reasons, making up only 1.5 per cent of all reasons to see a general practitioner.

Notes:

a. LCL/UCL as for Table 1.

b. Includes general check-ups, administrative procedures, cuts/lacerations, and other skin injuries.

Notwithstanding the lack of data regarding ADF primary care presentations, Tables 1 and 2 confirm the substantial differences between the ADF and civilian populations. In short, compared to their civilian colleagues, ADF general practitioners see proportionally far more musculoskeletal and mental health disorders, most of which

are either work-related or affect the ability of the patient to work.

Furthermore, these figures do not include non-primary-care ADF general practitioner presentations such as health assessments ('medicals') or Medical Employment Classification Reviews, both of which are occupational and environmental health functions. These presentations arguably consume 30-40 per cent of the average military general practitioner's workload, or about the same as their actual clinical workload.[12]

General practitioners and occupational and environmental health

The earlier paper refers to the extensive media commentary that demonstrates the need to improve how the ADF manages occupational and environmental hazards in its base settings. It also noted that thus far there has been no requirement for 'garrison' health services to facilitate local Command compliance with the *Work Health and Safety Act 2011.* This limitation, combined with a lack of occupational and environmental physicians within Joint Health Command, currently restricts 'garrison' rehabilitation and other clinical occupational and environmental health services to that provided by general practitioners and other non-occupational and environmental health providers.

Yet a review of the College of Rural and Remote Medicine's website confirms the absence of any internal occupational and environmental medicine courses. Furthermore, the only occupational and environmental health-related references in the Royal Australian College of General Practitioners' '2016 Core Skills Unit' of its 'Curriculum for Australian general practice' are two lines indicating that general practitioners are

Work-related reason	Number	Per cent of total	Rate per 100	5% LCL[a]	95% UCL[a]	Work-related as % of all
Musculoskeletal	1291	56.9	1.3	1.2	1.5	7.3
Psychological	299	13.2	0.3	0.3	0.4	2.3
Other work-related[b]	878	29.9	0.7	0.6	0.8	0.6
Totals	**2268**	**100**	**2.4**	**2.2**	**2.5**	**1.5**

Table 2: Most common work-related reasons to present to civilian general practitioners, 2013-14[11]

only expected to undertake an education and promotion role with respect to early return-to-work after work-related injuries or illness, and identifying opportunities to prevent injury and disease in at-risk individuals.[13]

The Royal Australian College of General Practitioners' curriculum offers 'contextual units' in military medicine and occupational medicine.[14] Other contextual units of less direct relevance to the ADF include travel medicine, individuals with disabilities, musculoskeletal and sports medicine, adult medicine, men's health, women's health, psychological health, abuse and violence, and addiction medicine. However, all these units consist of 2-3 page summaries, each only describing the relevance of the topic in a general practitioner setting, with very limited further references regarding the actual skills required.

The Royal Australian College of General Practitioners has a Military Medicine Working Group, which is developing a post-fellowship Diploma of Military Medicine that includes modules in public health, and occupational and environmental health. However, neither of the relevant Faculties of Public Health or Occupational and Environmental Medicine have so far been involved in their development.[15]

Furthermore, the Australian and New Zealand Society of Occupational Medicine Inc. is a professional society for those who practise or have an interest in occupational health. It seeks to advance the knowledge, practice and standing of occupational health by providing opportunities for professional development, networking and partnerships.[16] However, 'garrison' services have not yet mandated employing general practitioners from this or other occupational health organisations.

Civilian general practitioner training, therefore, provides a comprehensive basis for the *clinical* primary care of individual ADF members. However, it does not provide the full range of *non*-clinical primary care and other occupational and environmental health skills and expertise required for the ADF workforce. This further supports the author's earlier assertion that it takes up to 12 months for new full-time general practitioners to understand how to assess medical suitability for ADF employment and deployment, even without considering any other military occupational and environmental health functions.

ADF medical officer career implications

Defence requires all uniformed, Australian Public Service and contract civilian medical practitioners to comply with the registration standards of the Medical Board of Australia. Service medical officers currently have a four-level career structure, linked to remuneration, as follows:

- ML1: new entry medical officers who have not yet met all the requirements to be operationally deployable under remote supervision, pending further medical studies and Service training courses. All permanent medical officers are expected to initially undertake primary health care roles before diversifying into other streams. In practice, however, ADF medical officer recruiting is almost exclusively premised on an eventual civilian general practitioner career.

- ML2: medical officers who are deployable with remote supervision. Although it is intended that medical officers begin specialising into either clinical or management staff/force protection streams at this point, the aforementioned initial recruiting practices mean that exceptionally few are choosing the latter.

- ML3: primary health care medical officers, with either a Royal Australian College of General Practitioners or College of Rural and Remote Medicine fellowship. Most medical officers choose to leave the ADF at this point, which generally coincides with the end of their return-of-service obligation.

- ML4: medical officers who have achieved a qualification listed as a specialist medical qualification by the Medical Board of Australia, other than general practitioner. Among other specialties, it includes management/staff/force protection specialties, such as medical administration, public health, and occupational and environmental medicine. However, in November 2016, there were only two permanent ADF occupational and

environmental physician trainees, while public health and medical administration trainee numbers were probably comparable.[17]

An under-recognised medical officer retention factor pertains to the lack of diversity with respect to the clinical conditions experienced by the ADF workforce. Treating a succession of musculoskeletal and mental health disorders every day is unlikely to facilitate retaining Service or civilian general practitioner medical officers who prefer more clinical variety.

Consideration should therefore be given to recruiting and training more Service and civilian medical officers with an interest in an occupational and environmental medicine career. It is likely that they would not only maintain an interest in workforce primary health care but also accept that their eventual career progression to non-clinical roles is more consistent with their occupational and environmental medicine aspirations compared to their general practitioner peers. These 'garrison' occupational and environmental physicians would also facilitate local Command compliance with the *Work Health and Safety Act*.

Conclusion

With ADF personnel arguably exposed to the most diverse range of occupational and environmental hazards of any Australian workforce, high rates of preventable workplace illness and injury indicate the need to improve the management of occupational and environmental health hazards, with better emphasis on prevention rather than treatment.

This suggests that the ADF's health services should be premised on an occupational and environmental health paradigm, with revised fundamental inputs to capability that would lead to a genuinely holistic and sustainable workforce-based ADF health service delivery model by 2030.

Although general practitioners would still maintain an essential primary health care role within such a paradigm, they lack the skills and expertise to provide the full range of clinical and other occupational and environmental health services required for a young, fit, geographically mobile

and predominantly male (although this is changing) ADF workforce.

However, occupational and environmental physicians have the skills and expertise to provide primary health care for workplace-related musculoskeletal and mental health injuries, as well as managing workplace-based rehabilitation, and assessing medical suitability for employment and deployment. Such a delivery model would entail recruiting and training more Service and civilian medical officers who are interested in an occupational and environmental physician career.

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His seagoing service includes HMA Ships Swan, Stalwart, Success, Sydney, Perth and Choules. Deployments include Operations DAMASK VII, RIMPAC 96, TANAGER, RELEX II, GEMSBOK, TALISMAN SABRE 07, RENDERSAFE 14 and KAKADU 16. His service ashore includes clinical roles at Cerberus, Penguin, Kuttabul, Albatross and Stirling, and staff positions at Headquarters Australian Theatre, Joint Health Command, Director Navy Occupational and Environmental Health, Director of Navy Health, and Fleet Medical Officer (the latter from January 2013 to January 2016). Commander Westphalen transferred to the Active Reserve in July 2016.

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6   Examples where clinical primary care services have been essential to ADF humanitarian aid/disaster-relief operations include HABITAT (1991 aid to the Kurd population after the 1st Gulf War), TAMAR (1994-5 response to the Rwandan genocide), SUMATRA ASSIST (2004 tsunami), PAKISTAN ASSIST (2005 earthquake), PACIFIC ASSIST (2015 cyclone) and FIJI ASSIST (2016 cyclone). Primary care services are also intrinsic to the Exercise PACIFIC PARTNERSHIP series of humanitarian aid deployments, held in conjunction with the US and other partner nations since 2006.

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Cultural competence and linguistic capability in ADF human-intelligence source operations

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Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.

T.L. Cross *et al*, *Towards a culturally competent system of care*, National Institute of Justice: Washington DC, 1989

For some time, a range of government and non-government organisations have been acknowledging the importance of 'cultural competence' or 'cultural proficiency' in their service delivery and practitioner training. This has been particularly prominent in healthcare and social services, as well as law enforcement and the criminal justice system.

This article will argue that elements of cultural competence and related aspects such as effective linguist capability are integral to human intelligence in general, and military-related source

operations in particular. The article will then suggest how this can be better incorporated into both specialist and continuation training, and how linguist support to the capability can be enhanced to avoid cultural 'fouls' and missed collection opportunities.

As source operations are a human-intelligence discipline, it is explicit that human interaction is central to the capability. Throughout the selection, training, certification and employment of a military source operator (an individual trained to exploit information from a human source, most usually in an operational theatre), interpersonal skills are assessed and scrutinised. Psychological testing and observation of interpersonal interaction are used to ensure the right person has been chosen for a role which is critically dependent on understanding what is going on in the head of the person opposite them.

During the training of potential source operators, considerable scrutiny is placed on the exact

wording used during interaction with simulated sources. However, at present, almost all this scrutiny is conducted in a cultural and linguistic vacuum. With the exception of a short period of training in the use of an interpreter, all current training in the ADF is conducted between Australians and in English. This is continued during unit training, where training activities are almost exclusively conducted in a domestic context, with a simulated local source network.

Compare this to the actual conduct of source operations by the ADF. Almost exclusively, the gathering of human intelligence in an overseas theatre will be from sources who are foreign nationals, who either do not speak English or speak it as a second, third or fourth language. Less visible than the linguistic barrier will be their difference in world view. Understanding the motivation of a source is a critical component to effective human-intelligence operations. And, needless to say, the world view of a 42-year old father of three from Brisbane is substantially different to a counterpart from Kandahar, Dili, Mogadishu or Aleppo. Everything from sense of humour to honour, duty, loyalty and loss of face is subtly (or not so subtly) different when influenced by such factors as religion, educational levels, exposure to violence, and longstanding cultural norms.

At present, considerable effort is put into training to ensure that military source operators have the skills to pull the right strings when engaging with Australian role players. However, little preparation is given for re-tuning this skill-set to a source who may be Pashtun, Dinka, Arab or Melanesian. This cultural gap is currently addressed only by means of several pre-deployment 'culture briefs', which are largely untailored to source operations. Once in theatre, source operators learn 'on the job' and their most effective training in the local culture tends to be via the mistakes and missed opportunities of the first few months of their deployment. This is hardly ideal. Imagine a team of medical professionals deploying to an area with specific tropical diseases in the expectation that they would learn 'on the job'—so that after mistakes on the first dozen or so patients, they would begin effective treatment!

What is even more damaging and can delay the adaptive process for source operators is that they often have insufficient appreciation of how significantly different the subtleties of human interaction are from culture to culture. In other words, they typically are unprepared for how people from different cultures respond to questions from others—and often in different ways about different things for different reasons. Psychologists are divided as to the extent of the impact of culture on such fundamental aspects of human interaction. But it is clear that the cultural gap can be huge.

Recent experience in Afghanistan starkly demonstrates this gap. When an Australian is offended by a comment or joke made by another soldier, their response—unlike what has happened several times with an Afghan soldier—would never be to kill the person he days earlier had considered a good friend. Shame, honour and personal goals can all be significantly different to what a 'Westerner' might expect. Hence, source operators need firstly to be aware that all preconceptions and templated solutions need to be reassessed for each deployment. Secondly, they need specific preparation for that environment so they are among the most culturally attuned personnel deployed. This is often the case by the end of their deployment. But it should be the case at the beginning as well, where lost collection opportunities and cultural 'fouls' tend to occur, as illustrated at Figure 1.
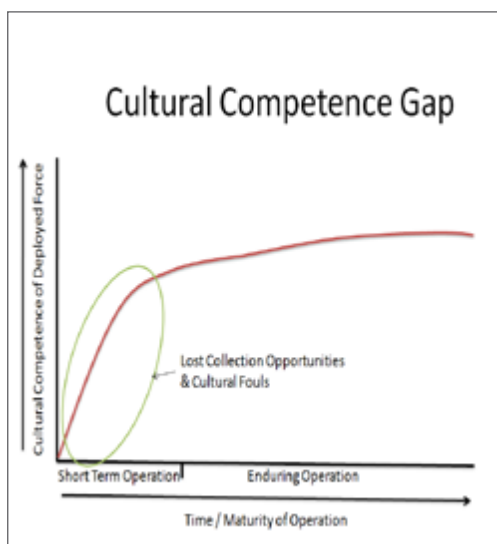

Figure 1: The propensity for lost opportunities and cultural 'fouls' to occur early in deployments

In addition to the issues of what is going on inside a source's head is the reality of what is coming out of their mouth. As mentioned earlier, source operator training gives particular attention to the exact language used by a source, scrutinising the language for ambiguity or lost meaning. Yet the availability and quality of interpreters on deployment can be so poor that the most basic question can readily be mangled into something with quite different implications.

Two major issues impact the availability of good linguist support. First is the need to have linguists or interpreters who are security vetted for the nature of the conversations being held. Second is the availability of linguist support in the specific language being used, including the correct dialect for that region and ethnic group. In an ideal world, a human-intelligence team would deploy with sufficient personnel trained in the local language, and to a standard high enough to replicate local language skills. In practice, this is highly unrealistic, even in regions in which Australia has been militarily involved for decades. As a Pashto linguist, the author can attest to the extreme challenges in teaching military personnel to speak a language which is so regional that even a native speaker from one province can barely understand someone from another.

The challenges in vetting local nationals to a sufficient standard are obvious in countries suffering prolonged instability, limited records and high levels of insurgent intimidation. The result is that field human-intelligence teams are typically forced to rely on limited numbers of contracted linguists provided by commercial companies, which usually source native speakers from diaspora populations in the Western world. Because of their lives in the West, these individuals can be vetted to a reasonable degree. Understandably also, these individuals are in high demand, and so are both expensive and few in numbers. The result is fatigued interpreters, notwithstanding that they often have extensive knowledge of a source network due to their high workload.

Nevertheless, these same interpreters, who tick the key boxes of vetting and language ability, may lack the necessary temperament or character. In human-intelligence operations, more than any other military activity, an interpreter must be in full unity with the individual they are working

for. In many cases, contracted interpreters are an excellent asset and are both hard working and capable. However, this is far from guaranteed. Complex conversational plans, concealed essential elements of friendly information and unspoken signals require a high level of synergy. A fatigued, arrogant or disinterested contracted interpreter, motivated only by a high wage, is unlikely to deliver this close cooperation.

So how does a small, specialised capability increase cultural competence and build a linguist support system which can assist with as yet unforeseen future operations?

Training cultural competence

Military source operator training needs to incorporate two distinct elements to achieve cultural competence. The first is to teach a generic understanding of the differences between cultures and the challenges this can produce in source operations. At present, this is usually delivered in an ad hoc manner via vignettes from the experiences of individual instructors. However, it should be formalised into a dedicated component of source operator training. It could, for example, be delivered as part of a pre-course study pack which required trainees to read historical cases of successful (and failed) source operations and the complexity of cross-cultural communication.

It could also be reinforced during training by amending slightly some role player parts to include certain cultural issues and requirements. For example, one serial could include an otherwise placid source taking offence over something very minor which then requires the trainee to apologise and identify how to rebuild rapport. This could be continued during further training, and elaborated with external presentations and study on relevant religious and cultural beliefs in likely areas for deployment. If the related security sensitivities could be addressed, it would also be invaluable to conduct training exercises in friendly countries to better incorporate and expose source operators to cultural differences.

A second element would be the delivery of effective pre-deployment cultural training to make human-intelligence team members among the most culturally attuned personnel on the deployment. This would need to include,

as a minimum, a study pack on generic cultural issues in that region, external lectures or engagement opportunities with diaspora communities in Australia (with suitable pretext), and a tailored reading list and appropriate funding to obtain study materials and books. By engaging with academic experts as well as appropriate analysts within Defence, a combination of experts could be utilised to brief and inform teams prior to deployment. This is every bit as relevant as reading into the reporting currently being produced in a respective theatre of operations, as it would provide the broader context in which that specific reporting is being produced.

Building adaptable linguist support

More complex would be the provision of appropriate and agile linguist support. The best way to achieve this is also one of the most difficult, that is, by developing military linguist resources tailored to human-intelligence operations. As it is not viable to maintain a large cadre of full-time linguists covering every possible language required, some risk must be taken in predicting which languages will be required. This prediction should look up to a decade into the future, which presents obvious problems in an unpredictable world.

However, it should be possible to produce a list of around half a dozen languages which reflect Australia's strategic collection priorities and anticipated areas of involvement. These languages should then form the basis for a two-tier approach to linguist capability. Following the example of the 2nd Commando Regiment, every source operator should be supported to develop their own basic language skills. This would require three things: direction, funding and specific time allocation for study.

Based on individual aptitude and operational requirements, each potential operator would be given a language to develop. They would then need to be adequately resourced by being provided access to high quality self-paced learning programs, such as the Rosetta Stone on-line language learning software which has been used so successfully by the British military. In addition, places on courses such as those offered by the

University of Queensland, or bespoke intensive courses using the Defence School of Languages could assist to deepen linguist ability.

Finally, dedicated periods of time would need to be ring-fenced to support learning, with operators held accountable for progressing their study in the allocated time. If, as a result of such training, Australia was able to deploy just two source operators to a new operational theatre with a basic understanding of the local language, it would prove of significant benefit to the quality of the human intelligence subsequently produced. The importance of language as a rapport-building tool is immeasurable. Even a limited vocabulary would allow the first rotation of intelligence-collection personnel to understand the local situation more quickly. It would also allow deployed source operators to quality-check their interpreters.

The suggested second tier of linguist support would be a cadre of dedicated ADF linguists possessing a high degree of fluency in one or more of the target languages. Existing linguists could be captured on a database for use by human-intelligence collection elements both on operations and in training (noting that language skills are already recorded on personnel records). In order to ensure these linguists were optimised to support such operations, a short course could be created to ensure they had a basic understanding of human-intelligence processes, requirements and considerations.

The inclusion of dedicated ADF linguists on exercises would also serve the double purpose of enhancing their ability to support source operations and provide training to source operators in working through interpreters. However, what would greatly enhance this capability is the targeted recruiting of a reservist linguist capability. Currently, linguist reservist capability is significantly undermanned and consists primarily of ex-Regular personnel. These unfilled Reserve positions could be filled with linguist support personnel recruited via University Regiments from students studying appropriate foreign languages. By advertising the financial benefits of having languages recognised in the ADF, appropriate candidates might also be enticed to join the Intelligence Corps and sit within the ADF's human-intelligence capability.

These suggested changes to both cultural training and linguist capability are small and relatively cheap by comparison to the cost of other intelligence-collection capabilities. They would, however, be significant in enabling an increase in the quality of human-intelligence reporting in the crucial early period of an ADF operation. The biggest barrier to their effective implementation is the current limitation in manpower and training time available within the ADF's human-intelligence capability. It would be necessary, therefore, to balance the importance of understanding (both literally and figuratively) the human terrain and the importance of other training that the ADF's human-intelligence resources are currently committed to.

As the world continues to be both unpredictable and volatile, it will remain vital for ADF commanders to appreciate the importance and complexities of human terrain as an aid to decision making. Human intelligence-related cultural and linguistic competence will continue to be a key factor in understanding complex environments across a range of operations from short-term humanitarian support to longer-term warlike operations.

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