JOINT HEALTH COMMAND
VICE CHIEF OF THE DEFENCE FORCE



Australian Defence Force

Mental Health Strategy 2002

Live Well, Work Well, Be Well

ADF Mental Health Strategy 2002

The ADF Mental Health Strategy 2002 was developed by ADF and Defence staff representing the Defence Force Psychology Organisation, Defence Health Service, Defence Community Organisation and Chaplaincy.

CHAPTER 1

THE PROVISION OF MENTAL HEALTH SERVICES IN THE AUSTRALIAN DEFENCE FORCE

Mental health is a key aspect of a member's overall health. A member can be completely healthy in other aspects, but if they are not mentally fit, their ability to function and perform their military duties may be partially or totally impaired.

(ADF Health Status Report 2000, p. 9-1)

The *ADF Health Status Report 2000* identified mental health as a key component of the health of ADF members and a key contributor to the personnel component of ADF capability. The report also clearly identified that mental health service delivery to the ADF is not coordinated and, therefore, not as effective as it could be. The report did, however, identify that a comprehensive ADF Mental Health Strategy (MHS) was being developed and that the MHS significantly informs the ADF MHS.

Purpose

The purpose of this chapter is to provide the background for the development of a strategy to deliver a comprehensive, effective mental health service for ADF members. This strategy will be known as the ADF Mental Health Strategy and will aim to provide ADF commanders with access to as many mentally robust personnel as possible.

Historical background

Mental health is a key feature in the delivery of the personnel component of military capability, however it has not always been a concern for military commanders. It was not until World War I that "shell shock" was noted and its impact on numbers of troops, bringing the condition to the consciousness of the British public.

During World War II, neuropsychiatric discharges were the single largest category of discharge from the U.S. Army and, in 1943, discharges on these grounds exceeded enlistments; in spite of the fact that over one million applicants were rejected on psychiatric grounds. One of the cited reasons for the high rate of discharge was inconsistencies in delivery of mental health services and, in particular, philosophical differences between the mental health service providers and the military.

Conclusion 1.1: Commanders are concerned about the long-term impact of operations on their personnel, although the key mental health consideration for commanders is immediate operational effectiveness.

Tension often exists between operational needs and the long-term well being of individuals – and this tension has been a perennial problem in military mental health. One of the key features of military mental health support is the concept, developed in World War I, of providing treatment for psychological casualties as early as possible. This concept focuses on treating symptoms and returning the soldier to military function as quickly as possible, rather than trying to provide a long-term 'cure' for what ails them.

During World War I psychiatry recognised that the environment was a prime contributor to an individual's state rather than any organic problem. Hence, a significant part of long-term individual treatment would be their removal from the war zone, with the expectation that the soldier would be 'cured' on their repatriation from the war. Unfortunately, this expectation proved unrealistic and during this war large numbers of soldiers who were probably experiencing some form of mental illness were shot for 'cowardice.'

The relationship between commanders and mental health problems has always been a difficult one. A psychological injury cannot be seen like a physical injury and military culture typically brands anyone who cannot perform, but has no clearly identifiable (i.e. physical) injury, as weak. As a result acknowledgement of mental health problems within the military, and their subsequent prevention and treatment, has been poor.

The military has, typically, not recognised mental health problems among service personnel until symptoms reach the stage where the individual can no longer perform their duty at all. An individual's mental health problems do not necessarily mean that they are completely unable to perform their duty, although they may be unable to perform their job to their full potential. The soldier's inability may be perceived as diminishing their commander's capability, although the responsibility for the mental health of service personnel remains with the commander.

Command responsibility

Psychiatric services have been officially used within the military since the early 1900s. At this time, however, mental health was either ignored or viewed by commanders as simply another function of the health services. As a result, commanders, passed the responsibility for the mental health of their troops over to their medical staff.

Physical injuries have generally been afforded a higher priority than psychological injuries. In most cases, medical officers have been trained as general duties medical personnel without the skills or confidence required to deal with the range of mental health problems confronting them. Additionally, many mental health casualties have often been perceived not as casualties but as discipline or morale problems.

Commanders often have a much greater impact on the mental health of their troops than they have control over physical health problems. Command and leadership, unit morale and cohesion are routinely cited as key factors influencing the mental health of military personnel. The responsibility to identify and take action on mental health problems should, therefore, rest with the commander.

Conclusion 1.2: The mental health of personnel is a command responsibility.

Current status of mental health in the ADF

The *ADF Health Status Report* identified that mental health in the ADF is currently poorly organised and fragmented in both its delivery and the extant policy used to guide the delivery of mental health services in the ADF.

There are a number of organisations within the ADF providing a broad range of mental health and allied services including DHS, DFPO, DCO, and Defence chaplains. While these services have generally demonstrated good informal communication, there has been little in the way of formal cooperation between them. In particular, each service operates under its own terms of confidentiality and treatment models, and there is very little sharing of information.

Conclusion 1.3: There is a requirement for greater standardisation and integration of ADF mental health service providers at the local level.

The policy environment

ADF Health Status Report 2000

The ***ADF Health Status Report 2000*** was produced by the Defence Health Services Branch (DHSB) to provide a baseline against which the health of the ADF can be referenced in future. Specifically, the report examines the current health of the ADF in terms of a number of key health indicators.

In the area of mental health, the report found that the available data was inadequate to assess the mental health status of the ADF. While some indicators were positive, these tended to be diminished by the lack of available data. Other indicators highlighted mental illnesses as being the second leading cause of medical invalidity retirements from the ADF; and that they were a leading cause of hospitalisation and working days lost in the ADF.

The report clearly identified the need for the development of a comprehensive mental health strategy for the ADF.

The National Mental Health Strategy

A National Mental Health Strategy has been extant in Australia since 1992, providing a framework for the delivery of mental health services to the Australian population. There are a number of key features of this policy that will shape the ADF's Mental Health Strategy; they are:

- Individuals are more likely to receive treatment when diagnosed with a specified mental illness. It needs to be recognised, however, that a much wider category of 'mental health problems' exist and that whilst they may be easily diagnosed, they are treatable.
- It is generally acknowledged that mental health services are currently provided within a community-based model. This model aims to improve the quality of service delivery and increase access to mental health services by the general community.
- Mental health services need to be better tailored to meet the demands of different community groups.
- There is a need for increased efforts in the prevention and early intervention of mental health problems, and improved strategies for the promotion of mental health.
- There is a need for increased research and evaluation studies in the mental health area, and for monitoring the outcomes of mental health standards.

The National Mental Health Strategy underpins the delivery of mental health services in Australia and should form the foundation of any mental health services provided to the ADF.

Conclusion 1.4: The mental health of ADF members may be affected by the inherent stressors of military service and operational service, life cycle issues and genetic dispositions, including:

- the development of an incapacitating and formally diagnosable mental disorder, or
- the occurrence of a mental health problem that does not meet diagnostic criteria and may not be incapacitating, but will impact on their effectiveness.

Conclusion 1.5: Mental disorders and mental health problems are treatable.

Conclusion 1.6: The ADF MHS must adhere, wherever possible, to the National Mental Health Strategy.

ADF mental health policy

ADF mental health policy relates to a number of areas and policy documents, including:

- entry standards
- critical incident management
- operational stress management
- preventative medicine
- health surveillance
- DFPO policies
- DCO policies, and
- Chaplaincy policies.

Entry Standards. The mental health and resilience of applicants is considered in both the ADF entry medical assessments and the psychological screening that occur as part of enlistment procedures. These procedures are detailed in ADFP701 Medical Assessment for Enlistment (Department of Defence, 1997), and the Psychological Services Manual (Department of Defence, 1997). The purpose of these procedures is to ensure that individuals entering the ADF are sufficiently mentally healthy to be able to withstand the rigours of military service. Individuals who are considered at high risk, including those with a significant history of mental disorder, suicide-related behaviour or substance abuse are likely to be screened out at this point.

Conclusion 1.7: The ADF starts with a population with less evidence of mental ill health than the general population.

Critical Incident Management. A number of single service documents provide guidance regarding the management of critical incidents and associated trauma. There is, however, no integrated or comprehensive policy document on this subject.

Operational Stress Management. ADF doctrine on operational stress is contained in ADFP 714 Operational Stress Management (Department of Defence, 1997). This document describes principles related to selection, training, cultural affiliation, pre-deployment psycho-education and personal support measures which, when implemented, aim to minimise the impact of operational stress. ADFP 714 also provides guidance related to operational stress and the management of critical incidents occurring during operations. The Deployable Health Capability Project addresses the importance of maximising psychologically fit ADF members for operational duty by providing quality mental health service delivery. This will be achieved by employing a multi-disciplinary approach incorporating psychiatrists, psychologists, social workers, chaplains, medical personnel and commanders.

Preventative Medicine. ADFP 717 Preventative Medicine provides the current doctrine regarding preventive medicine for the ADF. This document states that “operational personnel must achieve and maintain a high level of physical and mental fitness which will enable them to carry out their duties in military operations with drive, determination and efficiency” (par. 101). The document describes preventative medicine as including health promotion programs (e.g. health risk assessments,

counselling, physical fitness, nutrition education and periodic medical/dental examinations). It is recommended that these programs be accessed well before operational deployment to optimise the readiness and performance of ADF members.

ADFP 717 outlines preventive medicine measures directed at the highest levels of the command structure (via assessment of the health status of the command). The document refers to the importance of identifying the units requiring support (including the three services, Allied Forces, prisoners of war, indigenous civilians and detainees). ADFP 717 also includes an analysis of environmental issues (e.g. enemy and friendly situations, and characteristics of the Area of Operations). The document directs that specialist preventive medicine personnel are to identify and evaluate threats to the health of service members and provide advice accordingly to unit commanders.

On initial inspection, it appears that current doctrine may incorporate preventive mental health measures which parallel the above in terms of specialist assessment, advice, and policy promulgation and enforcement.

Health Surveillance. Defence Health Policy Directive No 128, 'Australian Defence Force Health Surveillance System"' (Department of Defence, 1998), states that health surveillance is essential for minimising preventable injury and illness in the ADF. The system aims to provide commanders with a quantitative means of assessing the general health status of their force and a means for the early detection of, and intervention into, diseases and injury. The surveillance system comprises a number of data collection interfaces and formats at the various layers throughout the Defence organisation. Collected data is analysed to determine the effectiveness, validity and future of prevention interventions and programs. The data also provides information that quantifies the costs of preventable injury/illness, contributes to health support capability development and planning, and establishes epidemiological databases for retrospective research.

At present, ADF mental health surveillance systems are ad hoc, fragmented and lacking in standardisation across the three services. Inclusion of mental health data within the existing health surveillance system warrants consideration.

DFPO Policy. Combining the three service psychology organisations into the DFPO has led to a lack of consistent service policy regarding the employment of ADF psychologists. A procedures manual, PSYMAN, has been developed outlining how the DFPO conducts business, but there is no extant policy identifying the specific role of the DFPO. Previous single service policy (there was no specific RAN policy, DI(A) Admin 10-2, and DI(AF) Admin 5-11) identified a variety of roles for the different organisations.

DCO Policy. Defence policy pertaining to the DCO is contained in DCM 102/95, DI(G) Pers 42-3, DI(N) Pers 90-8, DI(A) Pers 33-7 and Air Force Admin 12-18. The purpose of the DCO is:

"To contribute to the operational effectiveness of the ADF by providing a comprehensive range of social work, family liaison and education liaison support services and related programs, projects and research that enhance the well-being of ADF personnel, their families and communities" (DI(G) Pers 42-3).

The DCO provides specialist personnel and family support services to the ADF, its personnel and their families. DCO doctrine clearly identifies commanders as being responsible for the delivery of support services to ADF members and their families; and so DCO supports commanders to effectively undertake this role. The doctrine specifies, however, that the main role of the DCO is predominantly limited to in-barracks support. (Although DI(N) Pers 90-8 identifies that support may be provided during an operation, there is no indication that this is intended to include deploying DCO social workers to an AO.

Chaplains Policy. Policy guidelines for chaplaincy in the ADF is contained in a number of publications: DI(N) Pers 18/96, DI(A) Pers 170-3, DI(AF) Admin 4-9, DI(AF) Pers 5-15.

Navy chaplains are expected to advise the commanding officer on matters relating to the moral well-being of members and their families. This involves the provision of pastoral and counselling ministry, family support and trained members of Critical Incident Stress Management teams. The role of Army chaplains is threefold: to provide religious and pastoral support to commanders, to provide the same to soldiers, and to provide specific denominational services. This includes the provision of pastoral care and the "coordination of pastoral care activities with Army Community Services". Air Force policy on chaplaincy is less clearly defined, but the functional area of employment for RAAF chaplains does include 'Crisis Care Counselling'.

As identified in ADFP 714, chaplains are clearly seen as contributing to the management of stress in the AO. This supports the view that chaplains are a resource for commanders in the AO. It should be noted, however, that the chaplain was often the only mental health resource available to commanders in the absence of any other qualified professional. Some commanders even reported that when a chaplain was unavailable soldiers may be referred to "the most touchy-feely officer or soldier available."

The chaplain's role in providing mental health support may sometimes occur by circumstance rather than by choice. Chaplains have articulated that their first priority is to be a chaplain and minister to religion. The concern is that mental health support is a secondary task and may not be undertaken in times of duress.

Conclusion 1.8: There is a need to employ specific mental health professionals in dedicated positions in order to ensure that mental health support is provided to the ADF.

Conclusion 1.9: There is a range of mental health service providers able to contribute to the ADF mental health strategy.

ADF Policy Approach

The present ADF approach to mental health reflects a heavy emphasis on operational stress management. The main issues regarded as inherent operational stressors include environmental concerns, separation from family and, in particular, there is a heavy focus on traumatic stress. There is strong policy regarding response to trauma, reduction of costs and prevention measures in terms of enhancing capability and mental health. Procedures for affecting mental health primary prevention are not formally established, although preventive medicine policy and structure are well documented. It is intended that a collaborative approach to preventative mental health be coordinated by DHSB.

Currently, ADF doctrine describes existing primary prevention measures, including psychological selection on entry to the services and pre-deployment psycho-education. There is also mention of data management, realistic and relevant training, and the need for good administrative support in operations being important focal points for the future.

ADF doctrine does not raise the importance of family support policies, dedicated epidemiological research, leadership or organisational culture. Interestingly, literature on this subject appears to be less concerned about the operational outcomes of primary prevention than the mental health benefits for individuals.

Conclusion

The *ADF Health Status Report* suggested that ADF mental health services are lacking in coordination and comprehensive policy, and that a comprehensive strategy clearly needs to be developed.

There are a number of extant policies that will shape the development of the ADF's MHS. The National Mental Health Policy identifies a number of key features guiding the development of this strategy, including:

- a recognition of diagnosable mental disorders in addition to a much wider range of 'mental health problems' that are not necessarily diagnosable but that affect peoples' lives and functioning
- a community-based model of service delivery that improves the quality of and access to mental health services
- a recognition of differing needs across the community and for mental health services to be tailored to meet the demands of these different groups
- increased efforts in prevention and early intervention of mental health problems, and the development of better strategies for promoting mental health
- increased mental health research and evaluation studies and for the development of monitoring strategies and mental health standards.

These features must guide the development of the ADF's MHS. The considerations identified throughout the document must be incorporated into the strategy's development to ensure that the strategy meets the needs of the ADF.

CHAPTER 2

MENTAL HEALTH PROMOTION AND PREVENTION IN THE ADF

Definition of mental health

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal wellbeing, family and interpersonal relationships and contributing to community or society. Mental illness refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterised by alterations in thinking, mood or behaviour (or some combination of these) associated with distress and/or impaired functioning.

Defining mental health by the absence of mental disorder does not convey the full picture of mental health. Among its limitations, this definition excludes adults with mental disorders who function well between episodes of illness or those who function normally but require maintenance treatment to do so.

A number of factors are known to influence mental health and mental illness. There is also an emerging body of knowledge that links programs and policies with the factors that influence mental health.

Prevention

Prevention of mental health disorders is defined as "interventions that occur before the initial onset of a disorder" to prevent the development of disorder (Mrazek and Haggerty, 1994). Prevention interventions can be targeted according to different levels of ascribed risk within populations (Mrazek and Haggerty, 1994):

- Universal (primary) prevention strategies are aimed at improving the general mental health of a population by increasing awareness and education levels. Examples of universal prevention strategies may include building connectedness and a sense of belonging, developing coping skills and reducing high stress levels in a workplace. For the ADF, primary prevention strategies may include preparation before the event (e.g. 'inoculation') (Ursano et al, 1996), and can involve environment-centred and/or person-centred strategies (Armfield, 1994), which address management and leadership practices, and training and education activities. Primary prevention of general risk factors similarly affects and reduces the impact of traumatic stress in operations.
- Selective (secondary) interventions are targeted to population groups at increased risk of developing mental health problems and mental disorders. These populations may include young people at risk of depression and those newly divorced or bereaved. Secondary prevention strategies are aimed at early identification and treatment of mental illness with a view to assisting in the processes of experiences and limiting longer-term disability (Ursano et al, 1996). In the military context, early proactive treatment of symptoms typically follows the model of: Proximity (treat as close to unit and to fighting as possible); Immediacy (treat as soon as symptoms

arise); Expectancy (make the person aware that symptoms are temporary and that they are expected to recover and return to duty); and Simplicity (offer rest, replenishment and ventilation opportunities) (Armfield, 1994; Dobson and Marshall, 1996; Marshall, 1997; Raphael et al, 1996; McDuff and Johnson, 1992; Wenek, 1991).

- Indicated (tertiary) prevention interventions are targeted at people assessed to be at the highest level of risk and those demonstrating early signs of mental health problems and mental disorders. The goal of indicated prevention strategies is rehabilitation to prevent chronic disability (Ursano et al, 1996).

Both selective and universal prevention strategies aim to decrease the number of people who are above the threshold for mental health problems and mental disorders (Hart, 1999). Universal interventions are deemed to be desirable and risk-free (Mrazek and Haggerty, 1994) and generally have low cost per individual. It is postulated that, by anticipating and minimising the impact of trauma on military personnel, the duty of care to personnel will be met and the organisational price of combat reduced.

Effective prevention interventions should be informed by the population health approach and comprise prevention research, prevention practice, education and training, policy and organisation (Hosman and Engels, 1999).

Recommendation 2.1: All stages of prevention are appropriate within the ADF; however, universal prevention is most likely to have the greatest impact, be most cost effective and provide the greatest opportunity for manpower conservation.

Determinants of mental health and mental illness

The prevention of mental health problems and mental disorders depends on identifying and modifying the determinants of mental health and mental illness. Effective prevention requires:

- an understanding of the risk and protective factors for mental health
- identification of the groups and individuals who can potentially benefit from interventions
- development, dissemination and implementation of effective interventions.

Preventive researchers use risk status to identify populations for intervention with an aim to decrease the onset of mental disorders and/or reduce the potential for a recurrence of symptoms. This is done by enhancing existing protective factors and targeting risk factors thought to be causal and malleable.

The notion of risk reduction as a prevention strategy comes from a medical, epidemiological and public health perspective. This perspective seeks to identify internal (hereditary, biological, behavioural) and external (environmental, socio-economic, demographic) risk factors, minimizing their impact on the individual, family and community (Health Canada, 1997).

Addressing single risk factors or short-term prevention is likely to be ineffective. While reducing risk factors where possible and enhancing coping strategies are integral to prevention interventions, a concomitant focus on improving protective factors greatly enhances the effectiveness of interventions.

Risk factors are variables or characteristics associated with an individual that make it more likely that they will develop a mental health problem or mental disorder (Mrazek and Haggerty, 1994). Risk factors:

- exist before a mental health problem or mental disorder

- may be time-limited or continue over time
- can derive from the individual, the family, the community, institutions or the general environment and wider society, and
- can play a causal role or be a marker for a problem.

For many disorders, the risk factors are generic and it is not possible to determine which risk factors will lead to a particular mental disorder. Effective prevention programs thus tend to target a range of risk factors for a range of mental health problems and mental disorders.

Due to the complex nature of mental health, programs targeting multiple risk factors and using multiple strategies have better outcomes than those targeting only one risk factor or using only one strategy.

Many mental health problems share similar risk factors, so targeting those factors can result in positive outcomes in multiple areas. Also, some individual risk factors can lead to a state of vulnerability in which other risk factors may have more effect. The accumulation of risk factors usually increases the likelihood of the onset of disorder, but the presence of protective factors can mitigate this risk to varying degrees.

Because mental health is so intrinsically related to all other aspects of health, it is imperative when providing preventive interventions to consider the interactions of risk and protective factors, aetiological links across domains and multiple outcomes.

Risk factors

During the past 30 years a growing body of research has revealed some of the risk factors that predispose adults to mental health problems and disorders. The National Mental Health Strategy (2000) categorizes risk factors potentially influencing the development of mental health problems and mental disorders as including:

- individual risks
- family/social risks
- school/educational risks
- life events and situational risks
- community and cultural factors.

It is important to note that while the available evidence shows that these factors are associated with negative mental health outcomes, the strength of association and level of evidence for causation varies.

Stressful life events in adulthood may include:

- the break-up of intimate romantic relationships
- death of a family member or friend
- economic hardship
- role conflict
- work overload
- racism and discrimination
- poor physical health

- accidental injuries
- intentional assaults on physical safety (Holmes and Rahe, 1967; Lazarus and Folkman, 1984: Kreiger et al., 1993).

Stressful life events in adulthood also may reflect past events. Severe trauma in childhood, including sexual and physical abuse, may persist into adulthood or may make the individual more vulnerable to other stressors (Browne and Finkelhor, 1986).

Men are more likely to be involved in hazardous jobs and engage in unhealthy behaviours such as harmful alcohol use, while women are more likely to seek treatment for illness and are more aware of preventive health behaviours (Verbrugge, 1989). Research reveals gender differences in the performance of a range of self-care and prevention behaviours (Dean, 1989; Lonnquist, Weiss and Larsen, 1992). Gender also affects responses to a variety of stressors, including family discord and divorce (Luthar and Zigler, 1991). Solomon and Smith (1991) found men to be more adversely affected than women by personal exposure to disaster. By contrast, the study also showed that women are more vulnerable to more chronic or contextual stressors.

Although some stressors are so powerful that they would evoke significant emotional distress in most otherwise mentally healthy people, the majority of stressful life events do not invariably trigger mental disorders. Rather, they are more likely to precipitate mental disorders in people who are vulnerable biologically, socially, and/or psychologically (Lazarus and Folkman, 1984; Brown and Harris, 1989; Kendler et al., 1993).

Some kinds of stressful life events are encountered almost universally, however, certain demographic groups have greater exposure and/or vulnerability to their cumulative impact. These groups include:

- women
- young adults
- unmarried adults
- African Americans (indigenous Australian populations?)
- individuals of lower socio-economic status (Ulbrich et al., 1989; McLeod and Kessler, 1990; Turner et al., 1995; Miranda and Green, 1999).

Evidence related to the stress of deployment is consistent and it is unclear whether education, income levels and age affect levels of stress and coping. There is scope for more detailed research in the area of demographic variables and their relationship to trauma resilience and vulnerability. Cumulative adversity appears to be more potent than stressful events in isolation as a predictor of psychological distress and mental disorders (Turner and Lloyd, 1995).

Risk factors and the ADF – social, occupational and environmental stressors

Mental illness results from the complex combinations of events and conditions that occur in everyday life, including those based on biological, individual-psychological, social-psychological and structural factors. It is the interplay between the individual and the environment that is critical; and effective promotion and prevention activities are based on this premise.

Service within the ADF exposes personnel to specific risk factors in addition to risk factors existing within the general community. Stressors can be identified under the headings of social, occupational

and environmental. Many stressors can be categorised under more than one of these headings and it would be beneficial to define each category as it applies to the ADF. Examples of the various stressors are described below (Campbell, 2001), although these lists are not to be considered exhaustive.

Personal – issues pertaining to self as an individual and/or as part of a social system

- Separation/isolation
- Poor personnel support to families
- Secondary stress of family stress and its distraction
- Reintegration and reunion with family
- Harassment and bullying
- Lack of team cohesion and low workplace morale
- Rational people do irrational things when under significant stress
- Media coverage presents concerning images for families at home
- First time in active service, possibility of having to kill
- Leaders are often very self-critical and self-analytical on return to Australia

Environmental

- Pressures of having to adjust to living conditions in the AO – cultural differences, communal living, health concerns, poor adaptation on the part of some.

Occupational/Organisational

- Stress arising from conflicting duties / the types of duties performed – as part of one's normal role and as part of one's operational role
- Exposure to traumatic sights and experiences out of range of normal experience
- Conflicts experienced as a result of perceived deficits within Defence organisational or administrative structures
- Poor leadership
- Inadequate mental health services and support

The changing nature of military operation has given rise to the need to understand the nature of the stressors inherent in peacekeeping deployments and their consequences for individual well-being and organisational effectiveness. Whilst much research has been done into post-traumatic stress disorders (PTSD) and the existence of specific traumatic events, there is increasing recognition that other stressors play a role in peacekeeping stress. Litz (1996) summarised some of the potentially traumatising peacekeeping events as including:

- accidents
- abductions
- hostage-taking

- unpredictable attacks
- mines
- witnessing starvation
- mortar and sniper attacks
- witnessing atrocity, assassination attempts and violence (Campbell, 2001).

Some of the resultant psychological challenges from these events can include:

- helplessness and powerlessness
- guilt
- anger
- dread, terror and horror
- idealisation of survivors as heroic figures
- role-conflict
- confinement, boredom and isolation
- personal sense of vulnerability and intolerance
- moral conflict and disillusionment
- despair and demoralisation
- avoidance and/or withdrawal
- secondary traumatisation

(Litz, 1996; UNAMET Staff Support Team, 1999; Weisaeth, 1990 in Ward, W.K., 1997; Lamerson and Kelloway, 1996).

Recent studies of the psychological effects of military operations (Lamerson and Kelloway, 1996; Dobson and Marshall, 1996) have also highlighted that deployments are usually of a protracted duration (typically six months) and suggest that personnel engaged in such missions are therefore exposed to both traumatic and contextual (chronic) stressors (Campbell, 2001).

A recent ADF publication for soldiers deployed to East Timor (UNAMET Staff Support Team, 1999) describes typical stressors as: “unusual and poor living conditions, demanding workloads and a lack of recreational opportunities, separation from family and isolation, lack of logistic resources (administrative, transport etc), concerns about health (physical illness, susceptibility to infection and fatigue), dealing with the threat of violence which could result in personal injury, the witnessing of other people being threatened and harmed while being helpless to protect them, being exposed to a situation of chronic trauma, and cumulative stress from other missions’ (Campbell, 2001).

On the positive side, it is also feasible that peacekeepers can develop a sense of fulfilment and a deeper awareness of the human condition. Personnel can experience the privilege of witnessing the power of courage and the strength of compassion and renewed hope (UNAMET Staff Support Team, 1999; Weisaeth et al, 1996, Campbell, 2001).

Some of the most important environmental influences on mental health are opportunities that enable people to exercise control over their lives, to use their skills and to engage in supportive social interactions. Preventive programs should target the development of an ADF environment which is

conducive to these opportunities. Evidence suggests that organisation-wide approaches (targeting the structure and management of organisations, not simply individuals or groups within the workforce) are the most effective response to occupational stress management (Van der Hek and Plomb, 1997).

Recommendation 2.2: The ADF should aim to develop organisation-wide programs that reinforce an environment which enhances supportive social interactions.

Randomised controlled trials provide evidence of the efficacy of prevention interventions for adults affected by bereavement, physical illness, unemployment, divorce and separation, trauma and violence (Mrazek and Haggerty, 1994; Health Education Authority, 1997a and b). Given that exposure to trauma (both acute and chronic) is predictable in the case of deployed military personnel, it is essential to consider preventive, or at least minimising, strategies for unreasonable levels of stress. The aim of such strategies would be to prevent or curtail the development of chronic symptoms, to foster resilience and to enhance organisational effectiveness.

Recommendation 2.3: The ADF should examine the development of preventive strategies for dealing with trauma that may affect ADF members.

A broad range of studies has indicated that people need to accurately assess risk, acknowledging the reality of threats, in order to manage the potential effects of trauma. (Janoff-Bulman, 1983; Bartone, Adler and Vaitkus, 1998). In studying the negative effects of stress on Canadian peacekeepers serving in Rwanda and Somalia, Dobreva-Martinova (1998) stated that "the identification of stressors is an important pre-requisite for the development of stress prevention programs and stress management interventions". Once risks are identified, personnel should be provided with training to ensure their capacity to accurately address the risks and to target them with stressor-specific countermeasures. Developing appropriate countermeasures in consultation with mental health professionals was considered to be an important aspect of good command (Bartone, Adler and Vaitkus, 1998).

Recommendation 2.4: The ADF should actively engage mental health professionals to identify the mental health risks associated with operations and develop appropriate countermeasures to these.

An important step in attempting to manage stress-related psychological injuries is to be able to identify the source/s of such injuries. While some incidents may be readily identified, others may be far subtler. For some, the fear of letting others down is more important than personal risk. A thorough understanding, including individual perceptions of events, is required to fully assess potential stressors. This then, can lead to planning for appropriate management, the development of countermeasures and necessary intervention or treatment.

Recommendation 2.5: Stressful events should be routinely investigated by mental health professionals in order to gain a more complete understanding of the effects of traumatic stressors.

Protective factors

Like risk factors, protective factors derive from all domains of life: from the individual, family, community and wider environment. Some protective factors are internal (e.g. a person's temperament and level of intelligence), while others are external (e.g. social, economic and environmental supports). Protective factors enable individuals to maintain their emotional and social wellbeing and cope with adversity throughout life. They can provide a buffer against stress as well as a set of resources to draw upon to deal with stress.

There are many different kinds of protective factors, however four distinct protective 'processes' are consistently cited in the literature (Rutter, 1987). These processes include those that:

- alter exposure to a risk condition
- focus on harm minimisation
- enhance the development of resilience by promoting self-esteem and self-efficacy (Bandura, 1977)
- increase the availability of opportunities.

The National Mental Health Strategy (2000) presents protective factors that reduce the likelihood of mental health problems and mental disorders. It should be noted that while the available evidence shows that these factors are associated with positive mental health outcomes, the evidence for causation varies. Protective factors improve a person's response to hazards, resulting in an adaptive outcome (Rutter, 1979). Such protective factors may have an appreciable difference on the influence exerted by risk factors.

Specific strategies to build and enhance mental health resilience

The concept of resilience is central to most empirically based prevention programs. Resilience describes a person's capacity to withstand stress or adverse situations that might otherwise place that person at risk of adverse health outcomes. Factors that contribute to resilience include personal coping skills such as problem-solving, good communication and social skills, optimistic thinking and the ability to seek assistance when required. These skills are also known as mental health literacy, which is defined as "the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available; and attitudes that promote recognition and appropriate help-seeking" (Jorm et al, 1997).

Recommendation 2.6: ADF members should receive education that allows them to develop improved mental health literacy as an aid to enhancing the mental health resilience of the ADF.

Self-efficacy is defined as confidence in one's own abilities to cope with adversity, either independently or by obtaining appropriate assistance from others (Bandura, 1977) and is a major component of resilience. Raphael and Meldrum (1994), Creamer (1994) and Robinson (1994) note that the way an individual appraises an event is an important contributor to whether they later become traumatised by this same event. Specifically, if a person feels that they have the capacity to master a situation, they may experience less trauma.

These authors indicate that pre-trauma training (especially if it leads a person to understand normal reactions to stressful events) is important as it leads to increased confidence in one's own abilities. In describing programs to prevent acute stress reactions in emergency service workers, Robinson (1994) notes the role of education as a key strategy in assisting people to recognise stress and trauma, providing encouragement for stress management at the earliest opportunity.

Recommendation 2.7: ADF members should receive training aimed at improving their understanding of potential stressors and their confidence in dealing with stressors in order to improve their self-efficacy.

A number of researchers target coping skills as essential for psychological survivability during military operations and other traumatic events (Wenek, 1991; Pinch, 1994a; Taft et al, 1999; McFarlane and Yehuda, 1996). Programs should be implemented to develop individual resilience and to also train personnel to identify potential stressors.

In Stone's (1994) study of attitudes towards Critical Incident Stress in the RAN, 62% of personnel indicated that they had experienced a critical incident at some time in their lives, with 28% indicating that they had experienced more than one critical incident. Twenty five percent perceived that the risk of being affected by critical incident stress in their lives was high to very high. About the same number, however, indicated that they would be unable to recognise when they were experiencing severe stress. These results suggest that the experience of traumatic events is neither isolated nor rare, yet many are unable to accurately identify symptoms or the potential effects.

Marshall and Dobson (1996) argue that preventive measures should target stressors within combat zones, ensuring expectations are realistic, clear and achievable mission goals are provided, and all safety-related information is well articulated. Preventive measures should also occur after exposure to combat zones, including education about likely post-exposure symptomatology, training in stress management skills and facilitation of support structures prior to returning home.

Primary prevention for risk factors associated with military operations

Campbell (2001) discussed the four major categories of risk factors associated with military operations, including:

- personnel support measures: organisational management
- preparation and training
- cohesion and morale
- leadership and readiness.

Personnel Support Measures: Organisational Management

The literature suggests that there is much to be achieved from an organisational management perspective to ameliorate the psychological impact of combat exposure. For instance, it has been shown that the correlations between contextual stressors and job dissatisfaction are often stronger than the correlations between job satisfaction and exposure to combat stressors (Lamerson, 1995 in Lamerson and Kelloway, 1996). The implication is that peacekeepers perceive stressors to generally be controllable by the organisation (e.g. the UN Peacekeeping Force). There may also be a perception that the organisation exerts a stronger effect on job attitudes than do the uncontrollable stressors associated with combat. Potential stressors under the control of organisational management include:

- **Family and social support –** several researchers have advocated the importance of family and social support in minimising peacekeeper and other traumatic stress. Solomon and Smith (1991) found that the worst outcomes of two civilian disasters were experienced by single parents. The researchers also found that individuals who had not received adequate administrative or practical assistance were amongst the worst impacted emotionally.

- Studies of U.S Army veterans of the Gulf War, Wright et al (1991) found that most problems that surfaced early in the deployment were family related. In Gulf War veterans it has been reported that "unresolved interpersonal problems are associated with a higher incidence of battle fatigue" generally (McCaughey, 1991). Pinch (1994a) noted that family separation is a major contributing factor to stress amongst Canadian Forces personnel on peacekeeping operations. In a study of Vietnam veterans, Taft et al (1999) found that social support mediated the association between combat exposure and PTSD. In the context of Australian veterans of the peacekeeping force in Rwanda, Hodson (1997) determined that social isolation and support play a significant role in the development of PTSD symptoms.

  Tours of duty and management of exposure – within the realms of organisational control is the management of exposure to both acute and chronic combat stressors. Research has found that the greater the exposure to combat or the intensity of the battle, the higher the resulting rates of combat stress reaction (CSR) and PTSD (Ursano et al, 1996; McDuff and Johnson, 1992; Noy, 1987; Taft et al, 1999; Solomon, 1987; Ward, 1995). Exposure to combat can be regulated via rotational schedules and removal or exclusion of non-essential personnel from potentially traumatic operations and activities. Garland (1993) emphasised the importance of skilful management of evacuation and redeployment of personnel on military operations. In particular, issues of morale, cohesion, assignment of meaning and mental health interventions must be addressed.

  Logistics and administration of operations – to minimise contextual stressors on peacekeepers, military organisations must manage the administrative and logistics aspects of operations with the welfare of personnel as a priority. This includes medical and preventive health support (Wright et al, 1991; Pinch, 1994a; Dobson and Marshall, 1996; Garland, 1993; McCaughey, 1991; Ursano et al, 1996).

  Information and communications – good communications processes and accurate and timely passage of information are factors which will reduce stressors on personnel.

Recommendation 2.8: The ADF should review the organisational management procedures for all operations, ensuring they provide a supportive structure for all personnel.

Preparation and training

In discussing preventive measures for post-traumatic stress, Ursano et al (1996) states "Training can be used to limit exposure, alter the type of exposure, decrease surprise and the unexpected, and maximise the sense of mastery and hope (as opposed to hopelessness and defeat)".

Psychological preparation for military operations may also take the form of education regarding coping skills (Solomon et al, 1988). Dobson and Marshall (1996) propose preparing military personnel with an education program, including likely stressors in the area of operations, as well as information about coping techniques. It is recommended the program include:

- relationships with the civilian population
- a realistic appraisal of their likely role and contribution to the effort
- coping with changing personal relationships both at home and in the war zone
- realistic expectations of leaders

- stress management
- problem-solving
- conflict resolution.

The United Nations Department of Peacekeeping Operations (1995) describes pre-deployment training, including knowledge of what can be expected on missions, as important for peacekeepers. It notes that this knowledge "can greatly reduce the physical and emotional demands contributing to stress, even in the pre-deployment stage". Further, it is noted that pre-deployment training will enable peacekeepers to focus their attention on their given tasks. The basic content of pre-deployment training includes:

- the identification of stressors
- methods of managing stress on deployment
- methods of preventing PTSD
- post-deployment stress management
- ssues related to separation from family.

The ADF has included such a program as a mandatory component of pre-embarkation training for peacekeepers for the past decade. Also included in the pre-briefings is information regarding issues of adjustment on homecoming. Similar information packages are also provided to military families.

Wardlaw (1988) stresses the need to educate soldiers about likely reactions to the battlefield environment and adds that training exercises should include simulations of combat stress casualties and their treatment. Once again, exercises such as these are now included in Australian Army training operations.

Stress management training for each staff level is an important aspect of preparation for critical incidents and trauma, bolstering personal resources and increasing confidence in the management of situational disasters. Doing so frees the member from distracting emotional reactions, leaving them better able to concentrate on current operational tasks. While there are a variety of models for stress management training, most involve:

- education (and normalising) of reactions to stressful events
- development of skills to master and control physiological and psychological reactions to severe stressors.

As such, it is considered that such training should be a routine aspect of preparation for high stress or high demand operations. Stress management training should be incorporated as a routine aspect of training for combat and other occasions of high stress/demand.

Pearn (1999) notes that thresholds for acute stress can be raised by:

- prior training for the task-in-hand
- realistic training simulations of battle
- early recognition of and response to acute stress signs
- high unit morale, and
- a milieu of individual respect and support.

In her examination of stress attitudes and experiences in the British Army, Harvey (1996) made the following recommendations regarding stress management training:

- Stress education using acceptable role models is required to alter the negative and potentially harmful attitudes of some senior personnel toward stress related issues.
- Stress management needs to be taught throughout a soldier's or officer's Army career.

She stated that "there is a clear majority of personnel who accept stress as a valid problem and believe that there is insufficient support and training to manage it". Harvey (1996) also found that "confidence in military training is an important predictor of mental health problems, exemplifying the necessity to train all personnel effectively for whatever jobs they may do during their military career".

Clearly, training is a vital aspect of preparation for performance under high stress environments. A structured process of inoculating against stress ('inoculation' implies that, with training, a person may become 'immune' to stress. This is unrealistic – resilience is about facing inevitable stresses and managing these in a healthy way) and increasing resilience, allows personnel to maintain effectiveness and efficiency.

Recommendation 2.9: The ADF should review its current training to ensure that it is realistic and contributes to developing skills and confidence to reduce operational stress.

Cohesion and morale

A number of researchers have identified levels of unit or group cohesiveness and morale as contributing factors in combat stress and its prevention. Shaw (1983, in Dobson and Marshall, 1996) noted that group cohesiveness is one of a number of moderating factors in psychiatric breakdown in combat settings. Further to this, Lamerson and Kelloway (1996) stated that individuals working in cohesive units experience fewer negative effects as a consequence of traumatic stress. They propose that this may be attributable to either the increased confidence in the abilities of peers and leaders, or the provision of social support by other group members.

In a study of war veterans from Lebanon Milgram et al (1989) showed that group cohesiveness acted as a stress-buffer. The authors suggest that a cohesive military unit is especially effective in stressful situations due to the support offered by others with heightened empathic understanding. Hodson (1997), after studying Australian veterans of the UN peacekeeping mission in Rwanda, recommended soldiers be deployed as groups rather than as single individuals in order to capitalise on the positive effects of group cohesiveness. Similarly, she suggests that existing formations or units remain together on return to Australia to better provide post-deployment social support.

Litz (1996) found that veteran Somalia peacekeepers who reported few symptoms of psychological distress or PTSD were more likely to feel positive about military cohesion and morale during their deployment. Hoffman and Twining (1988) noted that the development of attitude and morale in Soviet soldiers represents the foundation for combat stress resilience. Garland (1993) also emphasised the importance of skilful management of issues of morale and cohesion in the management of personnel on military operations.

Developing and maintaining unit cohesion is a primary means of preventing or alleviating psychological injuries following trauma. The traits of groups in which military personnel exist and function may be more important than individual traits. This fact can be easily overlooked, as individual personality factors are often focussed on as the sole cause of breakdown. This then provides an urgent imperative

to understand the importance of cohesion, and developing the highest level of cohesion in all ADF units to protect against psychological injuries following trauma.

Recommendation 2.10: Routine ADF training and pre-deployment assessments should include a focus on methods to develop and measure cohesion amongst personnel. Cohesion should be developed from the time of a member's entry into a unit.

Leadership and readiness

Underpinning all primary preventive measures for the minimisation of trauma from military operations is the requirement for good leadership. Good leadership is essential for the effective assignment of troops to tasks and the identification and implementation of preventive strategies. Studies cited in Lamerson and Kelloway (1996) have reported significantly less incidence of PTSD symptoms in peacekeeping missions where unit leaders were assessed highly in terms of caring for members, ensuring their confidence and reactions to stress are closely monitored.

Some of the tasks of the unit leader in facilitating recovery from trauma are listed by Ursano et al (1996). They include:

- ensuring subordinates are properly trained
- maintaining an environment in which the work tasks can be efficiently performed
- ensuring effective product and service delivery from the organisational structure and operating procedures.

Further, leaders must aim to reduce the occurrence of traumatic events through enforcing safety standards and limiting exposure to hazardous situations. Consultation with mental health personnel, where applicable, should also be a responsibility of leadership.

Recommendation 2.11: Leaders, through their close contact with subordinates, can also be utilised to identify individuals at risk and arrange professional intervention as necessary. Leaders need to be educated to assess members potentially at risk.

Recommendation 2.12: Clearly there is a need to equip the ADF with the most current knowledge regarding the impact of trauma through military operations. This education needs to occur at strategic, tactical and operation levels at the highest levels of organisational management and policy development, down to unit commanders and leaders of the smallest of operational groupings.

Pre-enlistment and in-service mental health screening

Screening and selection

Psychiatric screening and outcome questionnaires have been advocated as an aid to the detection of cases and clinical decision making (Gilbody et al, 2001; Patten et al., 2000). Self-completed instruments such as the 12-item version of the General Health Questionnaire (GHQ) are:

- acceptable to patients
- have adequate sensitivity and specificity in their ability to identify disorders such as anxiety and depression
- sensitive to change.

The larger version of the GHQ (28 items), when it has been examined by factor analysis, has been found to contain three other factors in addition to anxiety and depression, including:

- difficulty in coping
- feelings of incompetence
- social dysfunction.

The routine use of these instruments might, therefore, be a simple and cost effective means of improving the recognition, management and outcome of psychiatric disorders in non-psychiatric settings. If psychiatric questions are to be of value, however, health professionals must routinely use them and act on their results. A further structured psychiatric interview is always necessary to make a psychiatric diagnosis. Other types of questionnaires include:

- the Beck depression inventory
- the Zung self-rated Depression Scale
- the Comprehensive International Diagnostic Interview Short Form for Major Depression (CIDI-SFMD).

Ursano et al (1996) quote many studies as showing that performance criteria may offer the best screening, rather than traditional mental health measures. In conjunction with these measures, however, the authors suggest findings on risk factors, including those with a history of psychiatric disorders(neuroticism, avoidance). It is also suggested that those within other high risk groups be incorporated into screening processes (including non-volunteers, women and those with mutilation fears who may be at greater risk when exposed to body recovery tasks) be incorporated into screening processes (Campbell, 2001).

It has been argued (Schmidtchen, 1997) that the types of qualities required in peacekeepers (e.g. restraint in the use of force, impartiality in action and resolution through mediation) are incongruent with conventional military preparation and training. Evidence suggests that screening and selection to ensure the right match of people to military roles can curtail the incidence of psychological casualties. According to Pinch (1994a), screening and selection standards applied (often informally) by Canadian Forces units have been instrumental in reducing administrative, medical, compassionate, disciplinary and other problems on deployments (Campbell, 2001).

Whilst the ADF selects its personnel on the basis of potential suitability for military training and adjustment in general terms, secondary screening and selection may be warranted to ensure suitable personnel for specific deployments. In a qualitative study of Australian peacekeepers, Schmidtchen (1997) identified both positive and negative qualities considered necessary. Similar requisite qualities for Canadian Forces peacekeepers are echoed by Pinch (1994a). Pinch (1994b) argues that attitude and behaviour screening should be a conjoint enterprise between personnel specialists and unit commanders. In a similar vein, Wenek (1991) proposes a two-stage screening process, where responsibility for initial screening is shared between unit commanders and their staff, and complex cases are referred to selection specialists for further assessment. A similar model was later proposed by Grandmaison and Cotton (1993).

Recommendation 2.15: The ADF should explore the introduction of mental health screening tools for ADF recruitment. These could form part of current medical examinations: pre-enlistment, in-service, post-deployment screening and discharge (in collaboration with the Department of Veterans' Affairs).

Identification and targeting high risk groups

Caution should be exercised in interpreting personality factors as predictors of current and ongoing mental health. Two studies, Moes, Lall and Johnson (1996) and Weybrew and Noddin (1979), showed that if personality factors had been used in selection, these personnel may have been excluded at recruitment. Yet, these people who may have otherwise been excluded, produced good work records and achieved promotion. There is also little, if any, data that indicates how many people with a pre-existing condition cope well, or whether pre-existing conditions are over-represented in those who have also suffered psychological injury following trauma. It is also unknown whether there are some personality characteristics predictive of those who don't suffer stress-related psychological injuries. However, Solomon et al (1987) found that soldiers who had the highest rates of Combat Stress Reaction (CSR) in the Lebanon war were those who had previously suffered a CSR. Those with the lowest CSR rates were those who had previously fought without incident.

Most psychological assessment methods focus on individual factors, with the assumption that combat performance can best be predicted by determining whether an individual has the capacity to maintain mental health despite significant stress. However, McCarroll, Jaccard and Radke (1991), contend that cohesiveness of the group or unit is a more valid predictive factor than individual personality factors. Manning (1994) noted that the group characteristics of military personnel in combat were much more predictive of mental health concerns than individual personality characteristics. This suggests that assessments of groups or units prior to deployment could lead to predictive assessments.

While the ability to select individuals for resilience to trauma is highly desirable, there appear to be only a few selection factors with significant validity. Even some personality factors usually considered dysfunctional might indicate increased resilience to trauma. The main factors contributing to a higher risk of trauma-related psychological injury include a history of psychological disturbance, especially anxiety (or neuroticism). There is, however, obviously no clear-cut answer to the question of how to select appropriately for high stress environments. There is also a need to look beyond individual selection, examining interpersonal and group factors, as well as environmental factors influencing risk and recovery.

Recommendation 2.16: The ADF should offer opportunities to gather and validate much more information than is currently being undertaken. A coordinated approach to gathering and analysing personal information should be introduced to validate the selection of personnel for high stress occupations or deployments.

Prevention of suicide and related behaviours

A first step in the prevention of suicide is determining those at risk of suicidal behaviour. For the Medical Officer, this involves performing thorough and objective assessments of suicidal risk with all patients, especially those presenting with emotional, mental, behavioural or occupational problems. It is important for Commanding Officers (CO) and individual members to be aware of risk factors for suicide and other factors that may precipitate a suicide attempt.

Clark and Fawcett (1992) found that approximately half of those who die by suicide have never seen a mental health professional. Only 7 to 20% of adolescents who have died by suicide had received mental health treatment in the previous 1 to 3 months (Brent, 1995).

Although suicide rates tend to be less in the military than in the general population, they still constitute the third leading cause of death in ADF personnel (***ADF Health Status Report***, 2000).

Motivations underlying suicides in the ADF appear to be similar to those for civilian populations with risks not necessarily related to the work environment, but instead associated with changing or unstable relationships, legal or financial status, mood etc.

The reasons for the generally lower rates in the military populations are likely to reflect a number of factors, including tight screening processes and lack of attractiveness of the military to some low-risk groups. The lower rates may also reflect the substantial support mechanisms of most Defence organisations, including counselling support health programs, alcohol and drug programs, stress management programs and free medical treatment. Additionally, Marshall (1992) noted that in the Australian Army, 75% of recruits, 24% of privates and 16% of higher ranks, are discharged within 6 months of committing a self-inflicted injury.

Suicide risk factors

The following factors are known suicide risk factors:

- presence of a workable suicide plan (especially with means to implement this)
- history of prior suicide attempts, gestures or threats
- male gender
- aged 15 to 24 years
- indigenous, culturally and linguistically diverse and other minority populations
- being unskilled, unemployed or pending separation from military service
- drug dependence or problematic use of drugs and/or alcohol
- presence of chronic physical illness or pain
- presence of mental health problems and mental disorders (particularly depression, psychotic disorder and drug/alcohol misuse)
- history of suicide within a person's family
- history of one or more psychiatric hospital admissions
- recent history of loss, including bereavement, separation, divorce or changing of significant relationships
- direct or indirect exposure to the suicidal behaviour of others
- presence of workplace conflict, especially situations involving shame or disgrace.

(Hawton and Catalan, 1987; Blumenthal, 1988; Patton et al., 1997; Martin et al., 1997; Allebeck and Allgulander, 1990; Graham et al, 2000; Cantor and Slater, 1995; Moscicki, 1995; Brent 1995).

Stresses particular to military life include:

- sudden and prolonged isolation from home and families
- restriction of choice and freedom
- imposed discipline
- numerous relocations to interstate and overseas postings
- performance anxiety relating to high expectations
- organisational ethos frequently promoting a culture of succeed or fail.

Marshall (1992), in his Australian Army study, found that suicide and attempted suicide rates were highest in the months of January, July and October. It is within these months that ADF members generally become aware of course outcomes and posting changes, or actually relocate to new postings. A study by the RAN found that six of the seven cases investigated in detail had been in their postings only a short time, averaging eight weeks. The high suicide rates associated with commencing and finishing military careers, with their requirements for major life transitions, also provide evidence for a link with relocation.

Every person who possesses several of the previously mentioned risk factors should be considered at risk for suicide, whether suicide threats are communicated or not.

Suicide Protective Factors

Individuals are considered to be at lessened risk of completing suicide if they:

- access emotional support from a genuinely caring support network including friends, family, peers or professionals
- have a belief that their burden/psychological pain will lessen at some point in the future. Once hope is lost, suicide becomes much more likely
- hold active religious beliefs that prohibit suicide.

Screening for suicide risk

Researchers have attempted to identify specific risk factors that are the strongest predictors of suicidal behaviour. Many studies have shown, however, that structured instruments to assess these risk factors misclassified many persons as high risk and (with some instruments) identified many as low risk who did commit suicide (Motto, Heilbron, Juster, 1985; Erdman, Greist, Gustafson, 1987; Pokorny, 1983; Beck, Brown, Berchick, 1990; Rydin, Asberg, Edman, 1990; Goldstein, Black, Nasrallah, 1991).

About one half to two thirds of persons who commit suicide visit physicians less than 1 month before the incident and 10 to 40% visit in the preceding week (Blumenthal, 1988; Robins, Murphy, Wilkinson, 1959). It is often difficult, however, for physicians to identify suicidal patients accurately. Direct questioning about suicidal intent is problematic as only 3 to 5% of persons threatening suicide express unequivocal certainty that they want to die (Pfeffer, 1986). A mental health clinician can identify established risk factors from the medical history, although the majority of patients with established risk factors do not intend to kill themselves (Mann, 1987; Murphy, 1983).

The development of a checklist of suicide risk factors is an appealing option. There is, however, a low base rate of suicides even amongst some high risk groups. Some studies (Erdman, Greist, Gustafson, 1987; Beck, Brown, Berchick, 1990) suggest that 15% of individuals who are alcohol dependent will commit suicide, leaving 85% who will not. A quantitative instrument would need to be especially sensitive, therefore, to identify specific individuals who are most at risk. Attempts to develop such an instrument have included systematically weighted and scaled standardised scales and tests incorporating high risk variables. With the exception of Beck's Hopelessness Scale, however, they have tended to lack reliability, validity, specificity and sensitivity (Pokorny, 1983; Beck, Brown, Berchick, 1990). Commonly, a number of false positives are identified, often leading to a prediction rate not much better than 50:50.

There has been little resolution regarding the use of screening tools to determine suicide risk assessment. The American Academy of Pediatrics (1988) recommends routinely asking all adolescents

about suicidal thoughts when taking medical history. The American Medical Association (1994) and the National Center for Education in Maternal and Child Health (1994) recommend that providers screen adolescents annually to identify those at risk for suicide.

The Canadian Task Force on the Periodic Health Examination (1994) found insufficient evidence to recommend for or against the inclusion of suicide risk evaluation in the periodic health examination. They recommend, however, that clinicians routinely evaluate the risk of suicide among persons in high-risk groups, particularly if there is evidence of psychiatric disorder (especially psychosis), depression or substance abuse, or if the patient has recently attempted suicide or has a family member who committed suicide.

Improved detection of risk factors by health professionals

In one study of completed suicides (Murphy, 1975), over two thirds of victims had made previous attempts or threats, although only 39% of their physicians were aware of this history. Psychological autopsy studies (retrospective psychiatric evaluation based on interviews with survivors) reveal that nearly all victims have evidence of previous psychiatric diagnoses (e.g. depression, bipolar disorder, alcohol and other drug abuse, schizophrenia) and previous psychiatric treatment (Robins, Murphy, Wilkinson, 1959; Mann, 1987; Rich, Young, Fowler, 1986).

Due to this lack of knowledge into psychiatric history, many primary care clinicians fail to recognise the presence of mental illness. Several studies have shown that depression and substance use, in particular, are frequently overlooked risk factors. Improved early detection of these conditions might help persons at risk of suicide, but further research is needed to evaluate its effectiveness in reducing suicide rates.

There is no evidence that screening the general population for suicide risk is effective in reducing suicide rates. Often, routine access to medical history is not, by itself, sufficient to recognise suicide risk or suicidal intent (U.S. Preventive Services Task Force, 2000). Several screening instruments have been developed to identify risk factors, but these do not accurately predict the likelihood of suicide. Even when a risk factor or suicidal intent is detected, there is weak evidence that interventions effectively reduce suicide rates. Several studies have evaluated the treatment of those who have attempted suicide, but results were conflicting and may not be generalisable to the population of those who complete suicide. Providing training to primary care clinicians may be effective in ensuring these clinicians effectively recognise and treat underlying mental health problems, but long-term controlled studies have yet to be performed.

There is insufficient evidence to recommend routine screening for suicide risk in asymptomatic persons. Clinicians should instead be alert to evidence of suicidal ideation, when the history reveals risk factors for suicide including:

- depression
- alcohol or other drug abuse
- other psychiatric disorder
- prior attempted suicide
- recent divorce or separation

- unemployment, and
- recent bereavement.

It is recommended that primary care clinicians be trained in recognising and treating affective disorders in order to prevent suicide. Patients who are judged to be at risk should be evaluated for possible psychiatric illness and be provided with counselling and referral as needed.

Most authors acknowledge the challenges of accurately assessing the risk of suicide, especially in individual cases, because the many factors involved are complex. Additionally, the number of people who actually commit suicide, and were already classified to be at a high risk of suicide, are a relatively small population. These same authors were aware of the need to ensure that individuals from high risk groups were fairly treated and resources allocated evenly to reflect this fairness. Nevertheless most authors who addressed the issue believed that the generally lower levels of suicide in the military could be maintained, or even improved, by adopting specific measures. Emphasis should be placed on strategies that involve systemic, integrated approaches, rather than piecemeal or specialist oriented programs.

Silverman and Felner (1995) argue that suicide prevention should focus on programs that target more broadly based risk and protective factors with an aim to reduce suicide and other social, behavioural and health problems. Underlying this proposal is the argument that many social, emotional and adaptive difficulties and disorders have common risk factors and, furthermore, the same protective factors are frequently relevant to a range of disorders. By placing suicide prevention within a more comprehensive prevention framework, the costs of primary prevention are applied to achieving multiple outcomes.

It has been estimated that as many as 90% of persons who commit suicide suffer from psychiatric disorders, so it is possible that treatment of these underlying illnesses may assist in the prevention of suicide (Blumenthal and Kupfer, 1986).

Recommendation 2.17: The ADF should evaluate the implementation of current policy addressing suicide-related behaviour:

- Health Policy Directive 209 Suicide – Management of suicide attempts and gestures by ADF personnel (Oct 91)
- DI(N) PERS 40-5 Management of Threatened, Attempted or Completed Suicide Within the RAN (Feb 96)

Recommendation 2.18: A tri-service suicide prevention program should be introduced to the ADF, targeting all personnel. A multi-disciplinary approach should be used and the program must include accurate data collection, processing and reporting procedures.

Recognising that suicide rates for military personnel are already less than for matched groups in civilian populations, some authors have emphasised the following as being particularly important:

- mandatory and/or freely available health support for military personnel
- availability of care-giving agencies for military personnel. It is especially helpful to have a well-advertised ‘hotline’ for health-related enquiries
- promotion of a healthy lifestyle inside and outside of the workplace.

Suicide prevention is more effectively addressed within a health promotion framework. This health promotion framework may:

- emphasise health, nutrition and fitness
- encourage a personal commitment to healthy living by members through education, training, leadership and peer pressure
- emphasise 'spiritual fitness', where ADF members adhere to and identify with the professional values and ethics of the military organisation
- include a range of programs in:
    - oral health
    - hypertension management
    - physical exercise and stretching
    - nutrition
    - weight control
    - smoking cessation
    - drug and alcohol control
    - stress management
- ensure all ADF members are aware of the health care and personal support systems available to them through such mechanisms as group or personal newsletters, posters and other advertising.
- involve mental health screening

Recommendation 2.19: Any suicide prevention program developed for the ADF should include a significant focus on the positive aspects of health promotion and the preventive factors for suicide prevention.

As a large percentage of victims had no contact with support agencies prior to their suicide, it is important that officers, managers and frontline supervisors possess the skills necessary to identify signs of suicide and make appropriate referrals. Marshall (1992), however, estimated that only about 0.23% of ARA personnel are likely to be associated with a suicide victim in any one year, and that attention drawn to the issue may increase the incidence. Systemic integration of awareness modules into routine leadership training and health promotion programs should, however, alleviate these concerns.

Recommendation 2.20: Any suicide prevention training must include a component that educates ADF commanders on their contribution to the prevention of suicidal behaviour.

Some authors have identified specific specialist groups of 'caregivers' and 'gatekeepers' that may benefit from training in suicide awareness, intervention and/or prevention. In addition to primary mental health care workers such as psychiatrists, psychologists, social workers, psychiatric nurses and those already likely to have received this training as part of their general training, the following may benefit from training in suicide awareness:

- medical doctorsmilitary police
- military chaplains

- military trainers
- members of Critical Incident Stress Management (CISM) teams
- other Defence personnel who frequently work directly with individuals identified to be at increased risk of suicide.

Recommendation 2.21: An ADF suicide prevention program should include training for specialist groups most likely to work with individuals at risk of suicide.

A key element supporting the development of an ADF suicide prevention program is the requirement for specific, clear, formal policies and directives regarding injuries (fatal or non-fatal) self-inflicted by any defence member. These policies and directives should advocate that every suicidal gesture or attempt should be treated seriously and as part of a positive organisational response.

Recommendation 2.22: The ADF must develop policy to support the development of an ADF suicide prevention program.

As indicated above, there is no evidence to screen asymptomatic individuals. Further research in the area of selection processes to screen out potential suicide victims, either directly or because of the voluntary nature of recruitment, should be undertaken. This could include the trial of specific instruments to accurately identify high risk applicants. For example, the General Health Questionnaire and Beck's Depression Scale could be used as potential trial instruments for those applicants indicated by other measures as requiring further investigation.

Recommendation 2.23: The ADF should undertake (or sponsor) research into potential suicide risk screening tools.

Problematic substance use

Prevention and early intervention activities need to identify people at risk of illicit drug use, with the aim of diverting these persons from progressing to drug dependence or other harmful drug use. The prevention of and early intervention into illicit drug use is considerably challenging, particularly when drug use co-exists with a mental disorder. Within the harm reduction framework adopted by the Commonwealth Government's National Drug Strategic Framework (Ministerial Council on Drug Strategy 1998), there is a focus on both preventing drug uptake and reducing the harm associated with drug use.

The AREP (Alcohol Rehabilitation and Education Program) was established in 1980 as a Clinical Flight of 3 RAAF hospital, RAAF Base Richmond, and was based on the US Navy Drug and Alcohol Program. Since 1980, the unit has treated members from the Australian Air Force, Army and Navy. AREP provides the only ADF inpatient facility for the treatment of alcohol dependence and provides a source of education and early intervention for ADF members who are substance dependent or experiencing harm from alcohol and/or illicit substances.

The RAN has a Drug and Alcohol Program that provides an education, early intervention and aftercare program for those who are alcohol dependent. The AREP program operates through a network of on-base counsellors, treating substance dependent RAN personnel who volunteer for participation in the inpatient treatment. The Army has a command-directed alcohol program in which commanders source and provide all education and early intervention to those using harmful levels of alcohol. Army personnel who are alcohol dependent are referred to AREP for assessment and inpatient treatment.

Problematic alcohol use is a significant problem in the ADF. Daily alcohol use in the ADF is estimated at 16 per cent and compares to that of the US military experience (17 per cent). The ADF rate of referral to AREP has increased steadily (since when?) and the rate of increase in women being referred has exceeded the rate of increase in men, although men are still referred at a higher rate than women. The estimated workforce cost of harmful drug and alcohol use per year is significant, with costs related to:

- reduced efficiency and productivity in the workplace
- potential for lower morale within the broader workplace, creating risks to both the user and their work colleagues
- treatment programs for drug and alcohol related illness and injury
- workplace accidents involving alcohol and/or drugs and the extensive compensation costs related to these, and
- workforce costs related to the loss of trained personnel and recruiting and training personnel.

The method for detecting illicit drug use in the ADF is by disciplinary action/investigation or as a result of a clinical examination with a patient's consent.

The incidence of drug usage convictions and administrative action varies between the three services and this may be secondary to differences in reporting, training, education and/or administrative reasons. The rate of drug use is unknown and an assessment of this is limited by the present methods of detection employed.

Service in the Army and Navy often involves frequent periods of deployment and training in isolated areas, in close quarters, in contrast to RAAF service where technical personnel often return home each night. The close contact of Army and Navy operational service allows for more rapid identification of any potential drug or alcohol problem in a serving member.

While there is no single ADF program addressing alcohol and other drugs, a report prepared by a tri-service, multi-disciplinary team has summarised strengths and weaknesses of the existing service policies (Sobering Facts; Options for an ADF ***alcohol management program***, Tri-service working party report, Department of Defence, April 2000).

In the ADF, all three services provide education regarding drugs and alcohol. The Navy program is the most mature and occurs at multiple points during service, including at recruit training and in operational units. The Army and RAAF have no formal education package beyond recruit training, but some ad hoc education sessions occur intermittently where a need is perceived within a unit.

The Navy also has a formal peer-based support program in which drug and alcohol peer counsellors in all ranks are trained and allocated to ships' companies. The RAN Alcohol and Drug Program (RAN ADP) has been running since 1984 and provides a framework for prevention and early intervention, and this program:

- provides the CO with assistance in the assessment, education, counselling and referral of personnel experiencing problems with alcohol and/or drugs
- monitors and supports personnel returning to duty following treatment
- provides advice on training for supervisory personnel, and
- delivers alcohol and drug education to RAN personnel at divisional meetings, staff seminars and other appropriate situations.

The primary weakness of the RAN ADP is that there has been no evaluation of the efficiency or effectiveness of the program, particularly in regard to the Substance Abuse Prevention Education Group (SAPEG), although some data collection has occurred.

The Army released DI(A) PERS 66-1 in 1994. This policy recommends measures to prevent alcohol misuse and provides direction to commanders for the management of members who misuse alcohol. It provides a good policy overview and refers to Defence leaders as the persons chiefly responsible for managing risks related to alcohol within the workplace. Despite this, COs and supervisors often receive minimal training to prepare them for their role of assessment, education, counselling, referral and support of personnel experiencing problems with alcohol or who have undertaken treatment. This lack of training contributes to the problem that many individuals with drinking problems often remain undetected and untreated while they are in the Army.

There is no formal monitoring of alcohol management within the Army. Consequently, the implementation of DI(A) 66-1 varies considerably across the Army, for the following reasons:

- general lack of awareness of the workplace risks related to alcohol
- limited formal structure for preventive education
- limited outpatient treatment programs
- limited formal aftercare for those leaving treatment programs.

The RAAF released DI(AF) PERS 4-14 in 1992. The aim of this instruction is to outline policy governing the consumption of alcohol by members of the RAAF and procedures for controlling harmful alcohol use within the service. This document offers a framework for preventing alcohol problems and identifying concerns as they arise. Similar to the Army, the implementation of DI(AF) PERS 4-14 varies considerably across the Air Force for the following reasons:

- Many members are unfamiliar with the DI.
- There are no formal structures for preventive education, and it is consequently not carried out. Personnel carrying out preventative education receive no additional training to perform this task.
- No training is provided for supervisors or COs to identify, interview or counsel members.
- Only an MO can refer a member to AREP.
- There is no structure for outpatient treatment for alcohol abusers.
- There is no formal aftercare.

Currently, there is little integration between the three services in the area of alcohol and other drugs and what does exist tends to occur on a local rather than overall basis. This ad hoc implementation suggests inefficient and inconsistent service delivery. To address these issues, an improved ADF reporting system should be implemented to track the number of inpatients, outpatients, injuries, surveys and deaths. Although HealthKEYS will make this sort of reporting feasible, there are significant ethical and confidentiality issues that may need to be addressed. Also, a study should be undertaken to estimate the current economic, social and personal cost of alcohol to the ADF and, in addition, the benefit-to-cost ratios of prevention and treatment programs. A central registry of illicit drug usage statistics for the ADF will also allow the development of targeted prevention strategies and monitoring of their success.

Recommendation 2.24: The ADF should evaluate the effectiveness and efficiency of its current alcohol and drug programs (RAN ADP and AREP) to determine their effectiveness and efficiency.

Recommendation 2.25: The ADF should implement a comprehensive tri-service alcohol and drug program that includes health promotion, prevention and early intervention, in addition to data collection and research into alcohol and other drug use.

Health promotion

Mental health promotion includes any action taken to maximise mental health and well-being among populations and individuals. It aims to protect, support and sustain the emotional and social well-being of the population by promoting that which enhances mental health. Mental health promotion is based on the premise that a community's emotional and social well-being can be enhanced through activities that build the community's capacity to support mental health.

Effective mental health promotion leads to changes in the determinants of mental health, regardless of whether these determinants are inside or outside of an individual's control. (European Commission, 1999). Mental health promotion incorporates the development of personal skills to enhance emotional and social well-being. In this way, increasing the emotional resilience of individuals benefits the mental health of the entire community (Health Education Authority, 1998).

Comprehensive approaches that use combinations of the following five mental health promotion strategies are more effective than single-strategy approaches:

1. building healthy public policy
2. creating supportive environments
3. strengthening community action
4. developing personal skills, and
5. expanding the orientation of health services (WHO, 1986).

Mental health promotion aims to optimise mental health and well-being in communities and, thereby, in individuals (Neuhauser et al, 1998). Examples of mental health promotion are interventions designed to increase the sense of belonging and connectedness within a workplace community. Such interventions focus on improving social, physical and economic environments that affect mental health, enhancing the coping capacities of communities and individuals (Wood and Wise, 1997).

The effectiveness of many promotion and prevention strategies is yet to be demonstrated, although the following interventions appear to be helpful:

- improving people's mental health literacy
- presence of an optimistic outlook
- problem-solving skills
- resilience to life stress, and
- social support. (Graham et al, 2000).

In recent years the United States Air Force has adopted a community approach to suicide prevention and preliminary findings have indicated a significant reduction in the suicide rate (USAF Instruction 44-154).

Randomised controlled trials provide evidence of efficacy for interventions for adults affected by adverse life events such as bereavement, physical illness, unemployment, divorce and separation, trauma and violence (Mrazek and Haggerty 1994; Health Education Authority 1997a, 1997b).

Within the ADF, the Defence Force Psychology Organisation (DFPO) is trialling a suicide awareness and prevention training package within Army Training Command units with the aim of developing a service-wide educational package.

For mental health promotion, there is currently evidence that parenting programs, as well as school-based and work-related programs, achieve positive mental health outcomes in terms of reduced risks and increased functioning (Hosman and Jane-Lopis, 1999; Tilford, Delaney and Vogels, 1997). A controlled trial has demonstrated that media campaigns, in conjunction with appropriate community activities, can improve mental health literacy (Hersey et al, 1984). Rigorous scientific evaluation of all mental health promotion programs will contribute to this emerging evidence base. Appropriate indicators of wellbeing and mental health promotion benchmarks need to be developed (National Mental Health Strategy, 2000b).

Mental health promotion is concerned with enabling people to maximise their well-being through influencing the environmental determinants of mental health. These determinants are broadly based in all aspects of life and, as a consequence, mental health promotion activities are often linked to improvements in physical health as well as productivity in the home and workplace. It is important to recognise that health promotion is a process aimed at giving power, knowledge, skills and necessary resources to individuals, families, the community and whole populations (European Commission, 1999).

To adopt a promotion and prevention approach, the ADF will need to select appropriate interventions based on the identification and selection of the targeted health conditions and the strategies that most appropriately address these. Strategies should be undertaken in partnership with relevant groups. In planning intervention strategies the following criteria should guide the selection of focus and intervention strategy:

- The extent of burden, e.g. incidence/prevalence/social and economic cost to the ADF.
- The empirical evidence demonstrating definite health gain and/or evidence of whether the intervention will address known multiple risk and protective factors.
- The availability and cultural appropriateness of the intervention.
- The effectiveness of the intervention (including cost/benefit analysis and timing of the intervention to maximise outcomes).
- The capacity of the intervention to adopt a population health approach (a large number of people exposed to a small risk may generate many more ‘cases’ than a small number of people exposed to a high risk).
- The intervention’s capacity to be effectively evaluated.
- The capacity to engage collaborative partnerships and/or strategic alliances.
- The capacity to engage stakeholder and consumer support.
- The potential sustainability and ability to apply the intervention strategy to other areas.
- The capacity of the intervention to address inequalities.

Recommendation 2.26: The ADF should develop a comprehensive mental health promotion program.

The National Mental Health Strategy (2000) National Action Plan (NHMS, 2000b) provides a sound basis for the development of an ADF health promotion program, including ADF-specific issues. It identifies two distinct target age groups of relevance to the ADF: young adults 18-25 years, and adults.

Young adults 18-25 years – preventive action

- Emotional resilience and a sense of connectedness to family, community and workplace.
- Positive intimate and other social relationships.
- Reduced risk factors for early psychosis, anxiety, depression and eating disorders, as well as substance misuse, self-harm and suicidal behaviours.
- Collect data on risk and protective factors, and identify effective approaches and settings across relevant service sectors that reach, attract, engage and retain young adults, particularly from high-risk groups, in relevant programs.
- Introduce initiatives designed to reduce the impact of adverse events (e.g. relationship break-up, imprisonment) that place young adults at high risk for mental health problems and suicide.
- Increase in programs that enhance education, work and career development opportunities for young adults.
- Increase in evidence-based programs to develop responsible and rewarding interpersonal relationships.

Adults – preventive action

- Social support and connectedness.
- Reduced stigma, discrimination, sexual harassment, victimisation and bullying in the workplace.
- Reduced incidence, prevalence and severity of stress and other health burdens associated with workplaces and organisational settings.
- Reduced risk factors for mental health problems and mental disorders, particularly those related to family violence and loss events.
- Pilot and evaluate workplace models of promotion, prevention and early intervention in partnership with relevant groups.
- Identify data, initiatives, needs and partnerships (e.g. unions, management, occupational health and safety) to develop a clearing-house on mental health promoting workplaces, policies and practices.
- Explore intervention initiatives that reduce workplace stress.

The ADF might engage in preventive activities including the development of a tri-service strategy which enhances an organisational culture that facilitates collective and individual mental health and well-being. Preventive activities might also include universal and specific measures, as listed below:

Universal prevention – all personnel

- Screening
- Education,
- Building and enhancing protective factors such as resilience
- Development of mental health literacy
- Ensuring organisational management is supportive

- Education of ADF commanders
- provision of a mental health network, including mental health professionals (MOs, psychologists, chaplains, social workers) and health services
- empowering families, and
- development of a comprehensive surveillance and evaluation program.

Specific occupations/deployment

Prevention activities that might accompany or aid a specific operation, deployment or occupational group include:

- screening
- education
- organisational management
- provision of a mental health network, including mental health professionals (MOs, psychologists, chaplains, social workers) and health services, and
- development of a comprehensive surveillance and evaluation program for specific groups.

Recommendation 2.27: The ADF should investigate the development of universal and specific campaigns and strategies that aim to prevent the onset of mental disorders and mental health problems.

Conclusion

The ADF has used a traditional medical model for the delivery of mental health services in the past with little emphasis on, or coordination of, the promotion of mental health or the prevention of mental disorders or mental health problems. However, there is a sufficiently significant weight of evidence and emphasis on this approach to dealing with mental health issues that the ADF should seriously consider incorporating this approach into how it deals with mental health.

When the implications of this approach for the conservation of military personnel, and in particular the positive role that commanders can play in contributing to this, are considered, it is clear that any future approach to mental health in the ADF must incorporate this approach.

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CHAPTER 3

Improving Mental Health Services delivery in the ADF

Despite the initial screening of ADF applicants and ongoing promotion and prevention strategies, mental health problems and disorders will occur within the ADF as they do in the general population. The ADF already offers a range of mental health services to personnel, although in the past service provision has been poorly organised and related policy has required review and standardisation. The development of the ADF MHS has presented the ADF an opportunity to implement integrated, multi-disciplinary mental health services based on public health and population based approaches (McFarlane, 2001).

Current ADF mental health services

Mental health services are currently provided to the ADF by trained DHS staff, including:

- reserve psychiatrists
- psychologists
- medical officers
- nursing staff
- social workers.

In addition, Defence Chaplains provide some informal counselling as part of their pastoral duties. Services are also provided through referral to external service providers, including consultants, the Vietnam Veteran's Counselling Service (VVCS) and Relationships Australia.

A full range of mental health services is generally readily available to ADF personnel within the National Support Area (NSA), although psychiatric consultations are often difficult to arrange in less populated areas. This is problematic given the concentration of military personnel in some rural or sparsely populated regions. Within the AO services are provided by DHS, DFPO and chaplains, but the level of service provision is dependent upon the duration and size of the contingent.

Several organisations also provide some mental health services and support to the families of Defence members, including DCO, chaplains and VVCS. Reserve members are entitled to access various mental health services when on military duty (including part-time, full-time or operational duty) and/or when the mental health problem or disorder is related to their military service (i.e. post-deployment). The ADF, therefore, provides various levels of mental healthcare tofull-time and reserve members and their families, however improvements to service delivery are required. In many ADF regions, mental health services and support are fragmented and poorly organised (ADF Health Status Report, 2000). This fragmentation frequently leads to a focus on treatment rather than prevention, in addition to specific problems related to readiness, quality of care, financial accountability and professional rivalry (Emonson, 2000).

Extant ADF mental health policy and doctrine exists within a number of organisations, areas and documents including:

- ADF entry standards
- Health Directives
- procedures of the individual service providers
- critical incident stress management
- operational stress
- suicide and related behaviours
- alcohol misuse and abuse
- preventive medicine
- health surveillance

The status of the above documents is variable, with many requiring review. In particular, there is a dearth of tri-service mental health policy, compounding the existing fragmentation of service delivery.

Preliminary contacts with international defence forces have indicated that strategic level mental health plans have not been developed. For example, various policies regarding US Army Combat Psychiatry and Combat Stress Control include service delivery structures, health promotion projects and research projects. The ADF already collaborates and shares information on mental health issues, although this level of international interaction may be better capitalised upon. Such communication currently occurs through:

- exchange officers
- international visits
- international conferences
- programs such as the American, British, Canadian and Australian (ABCA) Information Exchange Group on Combat Stress Management.

Delivery of mental health services in Australia

The National Mental Health Strategy (NMHS) was endorsed in 1992 to provide a national direction and framework for governments to reform services for those affected by mental illness. The strategy was articulated through several major documents, including:

- the National Mental Health Policy
- the National Mental Health Plan
- the Mental Health Statement of Rights and Responsibilities.

The NMHS, which is now in its ninth year and second major iteration, has resulted in substantial and ongoing changes in the provision of mental health services. As the NMHS has already completed an evaluation phase, it provides an invaluable opportunity to consider the successful and unsuccessful elements of mental health service delivery.

Major objectives of the NMHS included:

- the recognition of consumer rights
- the relationship between the mental health and general health sectors
- the mix between hospital and community services and between preventative and curative services, and
- the monitoring of the quality of the help provided to those in need.

A 1997 evaluation of the NMHS concluded that substantial change had occurred in the structure and mix of public mental health services. The range and quality of mental health services had improved, with services being more responsive, more community-orientated and better integrated with general health care. The NMHS was widely viewed to have been instrumental in producing, or at least accelerating, such positive change.
Despite these various gains, it was also reported that there was still widespread dissatisfaction with mental health services, with consumers reporting problems accessing services, poor service quality and stigmatising staff attitudes. Additionally, primary care providers complained of limited community-based services for those with mental illness who did not qualify for specialist psychiatric care.
Although significant gains had been made, much work remained to progress the strategy, and the implementation of the Second National Mental Health Plan was recommended.

The Second National Mental Health Plan 1998 - 2003 (known as 'the Second Plan') builds on the achievements of its predecessor, while giving prominence to three additional themes to guide reform:

- promotion and prevention
- partnerships in service reforms (between consumers and carers, and between professional groups), and
- quality and effectiveness.

These additional themes are in response to the findings of the ABS National Survey of Mental Health and Wellbeing (NMHS, 1998) that suggested approximately two thirds of Australians with a mental health disorder do not receive any form of treatment. The potential demand for mental health care is high and not being fully met by either the specialist or the general health system. The Second Plan provides a broader 'whole of community' focus, with a stronger emphasis on population health issues and interventions, aiming to build resilience and reduce future community morbidity (National Mental Health Report, 2000).

In the review of ADF mental health service delivery, the lessons learned from the NMHS should be considered, and in particular the need for:

- mental health services that are responsive, orientated to the needs of the community and integrated with general health care
- an accessible range of quality mental health services that address both mental health problems and mental health disorders
- development of strategies to avoid the stigmatisation of mental health problems by service providers as well as by the general ADF population
- service providers to actively implement 'whole of community' promotion and prevention strategies, as well as provide intervention and treatment

- development of partnerships (i.e. between professionals, commanders and consumers) during service reform and service delivery, and
- evaluation and review of service delivery under a strategic plan.

The ADF must be able to offer treatment options to its members both within the NSA and the AO, and improve the delivery of mental health service provision. Key issues are:

- What treatment should be provided?
- Who should provide this treatment?
- Where should the treatment be provided?

What treatment should be provided?

Mental health problems and mental disorders may occur in ADF members as a result of factors related and unrelated to their military service. For example, psychological stress may be attributable to any form of operational service (combat or peace-keeping deployment) or training activities. Psychological stress may also be attributable to personal relationships, bereavement or physical health problems.

There are also a series of other specific risks for ADF personnel, including:

- prolonged separation from family, friends and established support networks
- an increased risk of accidents, particularly during training
- frequent relocations
- imposed discipline
- restriction on choice and freedom, and
- interpersonal difficulties in service structures.

Mental illnesses and disorders encompass a vast range of physical, emotional, behavioural and cognitive symptoms, which can lead to a deterioration of the person's ability to effectively undertake responsibilities and perform daily tasks – inside and outside of the workplace. For operational effectiveness to remain of paramount importance, mental illnesses and disorders must therefore be appropriately and expeditiously identified, assessed and managed. This intervention should include a full range of prevention, treatment and rehabilitation services and be available to all ADF members regardless of the source of the mental illness or disorder.

Recommendation 3.1: ADF members should be able to receive treatment for any mental health problem or disorder, irrespective of its cause.

A concomitant problem is specifying the appropriate services for the families of servicemen and women. It is recognised that the DCO and chaplains have an important role in supporting families, but clearly there is a need for ADF families to be better connected to appropriate civilian services. Focus groups with ADF personnel (2001) revealed a belief that mental health support should be provided to families due to the unique nature and pressures of military life. The NMHS concurs, emphasising that an individual cannot be treated or supported independently from their social and personal circumstances.

Recommendation 3.2: The extant NMHS Standards for Mental Health Services should be adopted or modified for use by the ADF.

A key component of the NMHS is an established set of Standards for Mental Health Service, representing best practice in mental health service delivery. Evidence-based interventions have been identified for several common mental health issues including depression and anxiety, and the NMHS promotes these as a means to achieving improved outcomes. Standard evidenced-based treatments for known disorders have been found to be effective where they are specifically focussed on the identified factors for the individuals and the population (Raphael, 2000).

Recommendation 3.3: Any interventions developed within the ADF are to meet specific population needs, must be informed by current evidence based best practice and be evaluated.

Who will provide the treatment and where will the treatment be provided?

Mental health services can only be provided once an individual has sought assistance or has been referred for assistance. It must be noted that mental health professionals are rarely the first port of call for an individual with a psychological disorder (McFarlane, 2001). A key historical observation is that peers are often those who notice the development of mental health problems or disorders. There may also be situations, such as on operations, at sea or in remote localities, where immediate 'psychological first aid' will need to be provided by peers and commanders. It is, therefore, relevant that all ADF personnel be trained in:

- recognising signs and symptoms of mental health problems and disorders
- ensuring the safety of the person experiencing mental health problems and disorders.
- accessing appropriate mental health services

Given the stigma and prejudice associated with mental illness and fear of negative career consequences, there are major forces acting to subvert the active identification and management of psychiatric conditions in the ADF. Mental health education must aim to demystify and normalise mental health problems and disorders, and emphasise the concepts of rehabilitation and management.

Recommendation 3.4: There should be a requirement for all ADF personnel to have some training in the early recognition of mental health problems and mental disorders, and how to access services.

Although the provision of mental health support is not the primary role of commanders, chaplains, medics, military police or DCO, they do work with individuals in crisis. These persons must, therefore, have some skills in the identification and management of mental health problems and disorders.

Recommendation 3.5: There are a number of occupations and postings whose incumbents require a certain minimum level of education and skill in mental health identification and management.

All medical officers require appropriate levels of training and skill development in the identification and management of mental health problems and disorders. Non-specific health complaints, including anxiety and pain unrelated to any organic pathology, often present in those with underlying mental health problems or disorders. This emphasises the need for medical officers to develop a level of diagnostic skill which goes beyond the simple exclusion of physical morbidity and includes the capacity to diagnose associated psychiatric morbidity (McFarlane, 2001).

The range of mental disorders and problems is such that the provision of mental health support requires a broad range of skills and abilities. Generally, a high proportion of mental health problems respond to short-term (less than three months) outpatient treatment, normally involving counselling and sometimes psychopharmacological intervention. These persons are often supported within the

ADF by the DFPO, some medical officers, chaplains, and social workers. Consultation with ADF mental health service providers during focus groups (2001) indicated that issues involved in this level of service provision include:

- difficulty tracking the treatment (or management) of cases
- difficulty in the passage of information between individuals from different disciplines
- varying treatment standards, and
- difficulty coordinating treatment.

History also indicates that whilst military service can lead to the development of mental health disorders, service personnel can often be rehabilitated and continue to provide good service. These disorders normally require longer-term treatment, involving specialist psychiatric or clinical-psychological expertise. These skills are only available in a select number of military personnel, primarily clinical psychologists, Reserve psychiatrists and some DCO social workers.

In many instances, those with mental illness requiring longer-term treatment will be referred to a civilian provider with the necessary professional expertise, but without understanding of the military environment and culture. Commanders identified this lack of military understanding as a key failure by civilian providers (Focus Groups, 2001). There is a need for external service providers used by the ADF to be provided with appropriate training and education regarding the military environment.

The Defence medical system would generally refer ADF personnel requiring inpatient care to a consultant psychiatrist. These ADF patients may be either admitted to a service medical facility or transferred to a civilian mental health treatment facility, depending on the severity and nature of the condition to be treated and other local logistic factors. Although it is preferable to treat ADF patients requiring in-patient psychiatric care in close proximity to their work place and social supports, this is not always possible. Many of the psychiatrists undertaking the specialist care of ADF personnel have either been exposed to the military or are Reservists in one of the three services (Emonson, 2000). Many would, however, still benefit from greater familiarity with military training.

To ensure that high quality services continue to be provided by personnel with an appropriate level of training and skills development, a system of training and credentialing at various levels must be implemented. This system must be supported by ongoing and regular supervision. One proposal on the level of training to be provided to all ADF personnel and mental health providers, and the associated implementation strategies, is outlined in annex A.

Recommendation 3.6: DGDHS is to develop, in conjunction with DFPO, DCO and Principal Chaplain's Committee a system of training, supervision, and credentialing for all ADF mental health service providers at all levels.

The ADF needs to establish an integrated multi-disciplinary approach to mental health care delivery that aims to achieve optimum patient outcomes in terms of the member's health, well-being and operational readiness. Such a mental health care continuum should:

- be efficient and cost effective
- allow for communication through case management to reduce duplication in administration, and
- focus efforts on clinical service delivery.

Recommendation 3.7: An integrated, multi-disciplinary ADF mental health service should be established.

During combat, the rate of psychiatric casualties can represent at least 25% of the rate of physical casualties. This emphasises the importance of prevention, early recognition of cases and appropriate intervention, both in terms of the maintenance of morale and operational effectiveness. In addition to dealing with psychiatric casualties, a mental health service needs to be able to identify the psychological health risks within a particular operational environment and implement preventive programs, minimising any resultant long-term illness or disorder (McFarlane, 2001).

The provision of mental health services by DFPO and DHS on operations is significantly more integrated than within the NSA. The level of required mental health support is generally addressed during the planning phase of an operation, although ADF personnel receive psychological screening prior to deployment and on return from operations. For larger operations, psychology support teams are deployed alongside the contingent to provide immediate psychological support and undertake preventive measures. It is suggested that, as a minimum, there would be benefit in a system whereby deployed mental health providers can consult with a psychiatrist via telephone or other communication facility.

Recommendation 3.8: An integrated mental health service is required in the AO as well as in the NSA.

Future delivery of ADF mental health services

The aim of mental health services is to improve the mental health of the populations they serve, by improving mental health and lessening the burden of mental illness and disorder. To achieve these aims, mental health services must be provided in ways that are proactive and can impact on the relevant factors at both individual and population levels (Raphael, 2000). Within any treatment service, the social factors contributing to the health and ill health of that population and the ongoing issue of mental illness stigma must also be considered (U.S. Department of Health and Human Services, 1999).

A mental health service model provides a rationale for the operation of mental health services. The model needs to cover the whole of the lifespan of the population, and identify and respond to the mental health needs of the population served; proactively, responsively and reactively.

The ideal model should (Raphael, 2000):

- define the optimal structure for service delivery
- be easily understood
- be flexible and adapt to changing and emerging needs
- provide a functional system for effective, efficient, high quality programs across a spectrum of interventions
- operate on evidence-based practice and best practice in care provision
- achieve optimal outcomes in the improved mental health of the population and individuals
- ensure services are accessible to all members of the ADF and their families
- be capable of providing assessment and a range of interventions, and be able to evaluate these services, and
- meet the needs of the client population.

The key aspect of good service provision is a skilled and committed workforce supported by the appropriate infrastructure. This workforce includes both formal and informal care, and support networks.

An integrated mental health service working within a model of case management can be a vehicle for effective service provision and treatment. This service needs to encompass a population approach, rather than a more traditional medical model or specialist mental health service approach. This will ensure population health and prevention is incorporated as well as effective treatment. A mental health service that caters for *population health* needs encompasses assessment, morbidity, interventions and outcomes as determined and reported in the population. A mental health service that caters for *personal health service* needs provides services and programs to individuals within a clinical context (Raphael, 2000).

Assessment & formulation. The service must undertake comprehensive *individual assessments* to identify and diagnose problems and determine appropriate clinical management. The service must also undertake *population-based assessments* to determine the broad population needs and the burden of mental health problems and disorders. This can be achieved through health surveillance and monitoring (i.e., HealthKeys, ADF Mental Health Screen). This information will allow problems and issues to be defined, and the development of appropriate responses or interventions.

Interventions. As with prevention, intervention can be universal (e.g. all applicants are screened). selective (i.e. ADF Mental Health Screen administered post-deployment) or indicated (i.e. debriefs following traumas). Appropriate and early intervention relies upon case identification, whereby individuals presenting to primary care areas (i.e. medical centres) are correctly assessed and managed.

The provided intervention should be determined by a consideration of individual needs, population considerations and evidence-based best practice. Other vital components of intervention include the management of longer-term problems, rehabilitation and aftercare. The service must be able to provide optimal clinical treatment and requisite rehabilitation and support to those with longer-term or recurrent problems, to assist in the prevention of relapse and maintain optimal functioning of the individual (Raphael, 2000). Within the ADF, cases of chronic and disabling conditions may necessitate the managed separation of the individual from military service. Managed separation needs to involve appropriate referral to external service providers and organisations (e.g. DVA)

Integration of mental health services

There is a close link between physical and mental health, with physical and mental health disorders often occurring concurrently. This is one of the reasons that the services provided by health and mental health professionals can be integrated. Although a mental health service model may be integrated, there are different levels of care:

- **Primary mental health care.** This is the first and most broadly based level of mental health service provision and it is the most important level for the majority of ADF members. Service provision can include:
    - screening
    - assessment and diagnosis
    - intervention and management
    - provision of appropriate pathways to specialist care.

- Within the ADF this care can be provided by medical practitioners, supported by health care workers (i.e. medics, nurses, dentists and physiotherapists). DCO staff and chaplains and counsellors from services such as VVCS also provide this level of service. All of these persons require the skills and knowledge to be able to prevent, detect and effectively treat or refer those identified as at risk or affected by mental illness.
- **Secondary/specialist care.** At this level, service providers are able to provide specialist expertise in the assessment, formulation and management of mental disorders and the prevention of these conditions. These providers can assist primary care workers (i.e. medical officers) and support their management of personnel. Within the ADF, psychiatrists, psychologists, consultants and specially trained medical practitioners and social workers provide this level of service.
- **Tertiary mental health care.** At this level, services are required to deal with the more complex and severe mental health issues. Services can be provided within community or in-patient settings (i.e. clinical psychologists, psychiatrists, and in-patient PTSD programs).

The ability to provide emergency mental health care is an essential element of overall management. Currently, these services are available through various ADF facilities providing on-call and after-hours services. ADF personnel and their families can also access community-based facilities as required. In-patient services may be required for acute problems and civilian facilities are usually utilised.

Within these three systems of care, multi-disciplinary collaboration is essential to ensure the best management of a full range of interventions at both the population and the individual levels. One way of formalising integrated care is to provide multi-disciplinary case management of population and individual mental health problems. This model also includes the monitoring of outcomes (i.e., treatment results, prevalence) and the evaluation and review of all services.

ADF multi-disciplinary mental health service model

The introduction of an ADF multi-disciplinary mental health service model must:

- be able to provide ADF personnel with access to the most appropriate services
- be cost-effective
- avoid duplication of services
- facilitate early identification and intervention
- be centralised, and
- conform to privacy and confidentiality requirements (ROAC Psych, 2001).

The establishment of ADF Multi-disciplinary Mental Health Teams (MMHT) would facilitate this service model. These teams would consist of representatives from all three service levels, including DFPO, DHS, DCO, chaplains, VVCS, external service providers and key stakeholders. Key stakeholders and contributors to the mental health service in the ADF can include commanders and supervisors and Defence families.

Those not involved in direct service provision would be involved in regional meetings, provide advice and consumer representation and administrative management decisions. Due to the requirement to protect the privacy of individuals, however, these representatives would not be involved in clinical meetings or clinical case management.

This model ensures the most effective use of resources by identifying groups at risk and directing these individuals to the most appropriate mental health resources. The MMHT ensures the most efficient use of mental health resources by avoiding duplication and manages treatment so that intervention is the most effective and timely. The services provided by the MMHT would be coordinated centrally within a region to ensure appropriate management and referral occurs and that individual and population needs are fully met.

The multi-disciplinary approach provides opportunities for professional development, supervision and support, promoting effective working relationships between mental health professionals, consumers and stakeholders. The model also has the flexibility to be used within the AO as well as the NSA, although at a reduced capacity. Ongoing support can be provided via telemedicine even if only certain elements of the MMHT are deployed.

Successful implementation of the service model requires effective coordination and centralisation. A certain level of centralised record keeping and information sharing is required for effective case management. This will be facilitated through the implementation of Health Keys, involving clinical case management planning and liaison with other professionals. Any information sharing must be managed within professional privacy and confidentiality requirements (Rigby et al, 1998). It is essential that this element be carefully managed, as substantial barriers to effective mental health care exist due to a perceived lack of confidentiality and stigmatisation of those seeking mental health services (Focus Groups, 2001).

The MMHT should be developed at a regional level, building upon existing consultant psychiatrists and psychologists networks. The teams will be led by a senior clinician (i.e. psychiatrist and/or clinical psychologist) who will chair meetings, oversee clinical case management and provide professional supervision and support. The initial point of entry (POE) service provider will primarily manage actual case management, unless referral onto another primary case manager is determined to be more appropriate. In many instances, the case manager will be a medical officer as health services are often the initial POE.

Conclusion

The ADF already provides a range of mental heath care services to full-time and reserve ADF members and their families. Improvements to service delivery are required however, including improved coordination of service delivery and the development, review and standardisation of mental health policy. It is proposed that an integrated multi-disciplinary approach to ADF mental health care delivery be established. This approach should:

- be efficient
- be cost effective
- allow for communication through case management
- reduce administration time and costs
- focus efforts on all levels of mental health service delivery.

Annex

A. Mental Health Competencies for ADF Personnel and Implementation Strategies

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Annex A

Mental Health Competencies for ADF Personnel and Implementation Strategies

A competency-based model of service delivery has the benefit of involving a wide range of specialist groups in the delivery of mental health services, focusing on the competencies of individuals rather than on a particular category or specialisation. This is particularly important in military operations, at sea and in remote areas where a particular mental health care provider might not be available. It also provides referral mechanisms and supervision at every level.

Mental Health Competencies for ADF Personnel

Level	What	When	Who
Psychological First Aid	Indicated Prevention and Early Intervention	Immediate	ALL ADF personnel
Level One	Case Identification and First-Aid	Hours	Chaplains Social Workers DCO Liaison Psych Examiners Defence Equity Office Contact Officer Medics Nursing Officers Medical Officers Psychologists Clinical Psychologists Junior Commanders Others
Level Two	Early Treatment	Days	Medical Officers Psychologists Social Workers Psych Nurse Chaplains
Level Three	Standard Treatment	Months	Psychologist with appropriate clinical qualification or experience Medical Officer with appropriate clinical qualification/experience Social Workers with appropriate clinical qualification/experience Psychiatrist with appropriate military understanding
Level Four	Expert Advice and Supervision	Ongoing	Panel of Senior Specialists with relevant professional and military experience

Proposed Implementation Strategies

Issue	Strategy
All ADF personnel need skills in psychological 'First Aid'	Develop training course to provide all personnel with: • mental health literacy • listening skills • information regarding accessing mental health resources.
All ADF personnel need access to acute mental health support	Identify personnel to whom individuals with mental health needs present /or are referred. Develop training course to provide these personnel with competencies in: • case identification • psychological first aid • referral. Develop a 'Code of Practice' that addresses the professional standards for these personnel. Develop referral mechanism and protocols for referral to mental health professionals. Develop a mechanism to ensure structured supervision of primary care providers.
Early treatment of mental health problems is required in both the AO and NSA	Define competencies required for provision of primary/secondary services. Identify credentialing requirements and training needs to meet competencies. Develop referral mechanism and protocols for referral for primary/secondary management. Develop a mechanism to ensure structured supervision of primary and secondary care providers.
Standard and longer-term treatment of mental health problems required in the NSA.	Define competencies required for provision of specialist /tertiary mental health services. Identify credentialing requirements and training needs to meet competencies. Develop referral mechanism and protocols for referral for specialist management. Develop a mechanism to ensure structured supervision of specialist / tertiary care providers.
Expert advice and supervision of mental health care providers is required.	Form MMHTs to provide support and supervision, and provide advice on appropriate mental health management strategies. Improve the knowledge of military experts in mental health issues. Improve the military expertise of mental health experts.
Commanders need better advice on the mental health of individuals and groups under their command.	Formalise the requirement for MMHT at unit level to advise commanders. Provide education on mental health issues to commanders. Involve commanders in MMHTs.

Issue	Strategy
Effective communication between personnel involved in the provision of mental health care at all levels is required.	Develop recording procedures and referral protocols for use by all individuals providing mental health services. Formalise the requirement for regular case conferences including the principal members of the MMHTs. Examine the scope for Health Keys to allow shared access to relevant fields for both medical officers and psychologists.
Enhance ease of access to mental health personnel to facilitate early intervention.	Personnel with mental health training need to be active in the military community in both the AO and NSA.
Promote the well being of the family where it directly affects the well-being of ADF members.	Reinforce DCO and chaplain role in the MMHTs. Develop guidelines for assessment and referral for dependants. Develop mechanisms to assist families to access community mental health services.

CHAPTER 4

MANAGEMENT OF MENTAL HEALTH PROBLEMS IN THE ADF

Introduction

Mental health is a key aspect of a member's overall health status. The recognition of its importance has been demonstrated by its selection as one of the five elements of the National Health Priority Areas (ADF Health Status Report, 2000). It remains, however, an element that is poorly understood by military commanders and general health practitioners. Military leaders currently spend significant time managing mental health related issues that detract from individual and unit readiness. Such issues include alcohol related incidents, productivity losses, general disciplinary processes and workplace accidents. Service personnel who experience high levels of work or family stress are twice as likely to experience injuries due to accidents in the work environment (Jones, 2000). Many of these problems are attributable to, or exacerbated by, mental health concerns such as depression, alcohol abuse or difficulties coping with stress (Jones, 2000).

A definitive mental health intervention is initiated only when a person presents for management of an acute problem or when administrative processes indicate an underlying mental health concern. For a number of reasons, which are discussed later in this paper, this intervention may be delayed until the condition has become a major barrier to the member's continued service. The mental health of the service member remains important regardless of their capacity for deployment, so any strategy or mental care focus must consider the service member's environment.

Mental health screening processes are applied to the member at the time of proposed enlistment to identify barriers to service (ADFP 701). These processes assist in the identification of significant mental health problems but do not allow for intentional and deliberate masking of screening results. Unless a specific requirement for further examination arises following self or practitioner referral, or until a specific element of service demands mental health assessment, the effectiveness of this screening is limited.

Scope

This chapter will address the management of specific mental health issues relating to specific ADF occupations and the development of an integrated mental health approach. A subsequent section will review mental health issues in relation to separation from the ADF and transition to civilian care.

Aim

The aim of this chapter is to identify considerations of mental health care for inclusion as elements of the ADF MHS.

Management of mental health issues

Assessment. The ability of ADF members to deploy on operations within Australia and overseas is derived from the member's individual degree of readiness (DI(G) ADMIN 36-2). This readiness is ascertained by a number of factors that refer to general levels of health, including medical, dental and mental well-being.

Assessment of individual health is addressed in DI(G) PERS 16-15. Individuals are assessed and provided with a Medical Employment Classification (MEC). MEC incorporates the respective level of mental health, although further research is required to ascertain appropriate relationships between specific conditions and the subsequent MEC allocation.

Single service categorisation of elements of health is addressed quite differently. RAN and RAAF assessment processes do not include identification of the appropriate mental health grading under the MEC grading system. The Army, however, uses a structured profile of body or system health assessments called PULHEEMS. This acronym is used for the categorisation of health or fitness, where each letter (category) is granted a numerical value from 1 to 8, with 1 being the preferred and 8 the least result. PULHEEMS categories relate to the individual's:

Physical capacity
Upper limbs
Locomotion
Hearing
Eye (R)
Eye (L)
Mental capacity, and
emotional **S**tability.

M or **S** categories relate to issues within the mental health assessment. Mental capacity relates to the ability of the applicant to understand and appreciate an instruction and to express themselves. Emotional stability assesses the ability to withstand physical and mental stress that may be associated with service employment. These categories are ascertained by a medical practitioner in the course of the general medical examination and do not necessarily involve a psychiatric specialist or psychologist. In accordance with ADFP 701, the examining medical officer is not required to conduct a full psychological assessment. Each person applying to enter the services is subjected to an interview with a psychologist, as well as undertaking a battery of psychological assessment instruments.

There is little data indicating that those with pre-existing mental health problems and disorders will fail to cope with the stresses of service life, or whether in fact they are any more vulnerable (Rayner, 2000). Regardless, the immediate concern is that consultations between the examining medical officer and the psychologist may be initiated by either, dependent on circumstance. This does mean that the screening and selection of candidates are conducted in relative isolation and notated in different areas of entry paperwork.

Special to occupation grading. Physical and mental restrictions are applied to selected trade or employment groups within the ADF and the required functional capability is considered for each role. Personality factors usually considered dysfunctional may actually indicate increased resilience to psychological trauma (Rayner, 2000). Health restrictions, including mental health considerations, are applied to aircrew, diving and submariner employment groups. Other categories requiring closer assessment include Special Forces selection processes and individuals:

- with access to demolition training
- undertaking politically sensitive postings
- undertaking competitive, demanding or resource-intensive training processes.

Incidence of mental health problems in the ADF. Current data available to assess the ADF's mental health status is fragmented and incomplete (ADF Health Status Report, 2000). A centralised database containing comprehensive figures on the prevalence or incidence of mental health concerns does not exist, although the development of Health Keys offers an opportunity to remedy this. In the intervening period, strong inferences can be drawn from a number of environments and agencies in which some information has been collated. This report has examined data held by DVA and DefCare in an attempt to identify the true magnitude of the problem. Some meaningful data has been collected but this is likely to provide an indication rather than a comprehensive summary.

Drawing a direct correlation between the civilian and military communities is not possible due to the significant demographic differences between them. Due to the screening processes at enlistment, the military is likely to commence with a population that is healthier than that existing in the community; however the stresses and stressors inherent in ADF employment apparently redress this initial comparison. It is perhaps not surprising, given this assumption, that RAN and Army members have higher admission rates for psychiatric/psychological reasons than that found in the civil community (DVA Mental Health Study). Corresponding rates within the RAAF are considerably lower than those existing in society. Explanation of these factors, and of the true incidence, is not possible until there is a better understanding of the criteria used to measure the prevalence of mental illness and disorder.

Delivery of mental health care. The delivery of mental health care within the ADF is the shared responsibility of the DHS and the DFPO. The involvement of the respective organisations depends on the nature of the mental health issue.

In circumstances of psychiatric intervention, the primary assessment and initial treatment is conducted by generalist medical officers in an outpatient setting. In cases of significant or chronic psychiatric morbidity, the treatment incorporates referral for management by specialist personnel, trained and qualified in psychiatry. Depending on the severity or nature of the condition, members requiring in-patient care may be admitted to service medical facilities or to a civilian mental health treatment facility. In the case of mental illness arising during an operational deployment however, the sole option is hospitalisation. Additional mechanisms of treatment include administration of medication or the involvement of other professional members of the mental health care team.

Mental health concerns are not limited to the diagnosis of psychiatric problems. Much of the incidence of mental ill health relates to:

a) the stresses of day-to-day life, or

b) a decrease in coping mechanisms experienced as a direct result of service employment.

These conditions of anxiety, stress or reactive transient depressive episodes are often a result of relationship conflict and/or separation and divorce. They may result in referral to a clinical psychologist, although possibly not psychiatric intervention. Depending on the severity of the condition, treatment modalities may include hospitalisation or multi-disciplinary involvement enabling counselling and psychopharmacology measures.

Two factors serve to mask the true incidence of mental health problems in the military environment. Firstly, seeking assistance may be perceived as a sign of individual 'weakness' and a potential risk

to the integrity of the service environment. Due to this perception, treatment for a psychological or psychiatric condition is considered to negatively impact on the member's career and promotion prospects. Secondly, attendance for treatment of a mental health concern carries an element of social stigma. Both of these factors create a strong potential for the denial of the illness or disorder or for self-referral to an external service unrelated to the military health system. As a direct implication of these factors, any indicators used to demonstrate the magnitude of mental health concerns will almost certainly understate the problem.

Where ADF members do seek internal support for mental health issues, in the first instance they commonly make contact with a member of the Service Chaplains Department or the DCO via a member of its social work team. Under the present mental health care delivery mechanism, it is possible that any of the above professional agencies may be treating or supporting an ADF member in isolation. Service chaplains and other ADF personnel with the capacity to make appropriate mental health referrals do not do so in a prescribed or structured fashion, instead relying on the level of liaison and willingness of the presenting individual. Regardless of the lack of integration of these agencies in the care of service members, these non-clinical points of contact are acknowledged as being vital participants in the provision of mental health care.

Clinical reporting of a mental health issue remains a fragmented or unconnected process. Professional responsibilities and confidentiality issues prevent a multi-disciplinary, concerted approach to psychological or psychiatric problems. Accessibility of clinical notes and cross-referral must be inherent elements of any strategy of mental health care provision.

SEPARATION FROM THE ADF

Reasons for separation

Separations from the military can arise at the completion of a fixed term of employment or at any time within the duration of enlistment or appointment. In the context of mental health, any separation can have administrative elements reflecting a disciplinary basis or overlay, or be subsequent to a request for release initiated by the member who is sufficiently disillusioned with or unable to continue actively within service life. The prevalence of mental health issues in these routine, administrative separations is a matter of conjecture and cannot be validated by data currently held.

Some statistics on the incidence of mental health concerns are held by a number of Defence and related agencies. DefCare has provided a summary of claims lodged for compensation over a five year period. These figures demonstrate the nature of claims involving some change in the mental health state of serving personnel.

Table 1: DefCare Claims for Compensation 1996 - 2001

	1996	1997	1998	1999	2000	2001 (2)	Total
Total Claims	6485	6135	6115	5741	5538	1364*	31378
Anxiety	38	38	58	43	47	7*	231
Depression	35	32	55	52	48	5*	227
PTSD	35	45	56	68	95	16*	315
Stress	33	35	21	15	10	5*	119
Schizophrenia	2	4	4	5	0	1*	16
Mental condition (1)	7	7	2	6	6	1*	29
Total	150	161	196	189	206	35*	937

Notes: 1. Indicates non-specified condition where 'mental' is contained in the claim

2. Part-year figures only

A number of trends are apparent within Table 1. The identified psychiatric diagnosis of schizophrenia is of extremely low incidence and possibly indicates the effectiveness of existing pre-enlistment screening processes. The rate of anxiety, depression and stress incidence is decreasing, however there is a corresponding increase in claimed PTSD conditions. These figures probably reflect the more specific diagnosis of the condition rather than the generic identification of the primary symptom. Regardless of the interpretations, there is sufficient evidence of mental health disabilities within the population. However, it must be remembered that this reflects only the reported incidence and cannot be assumed to be representative of the full picture.

The DVA receives a number of claims relating to mental health problems, from personnel separating from the services. The figures provided in Table 2 reflect the situation for the period January 1997 to June 2001.

Table 2: DVA Mental Health Disability Claims 1997 to 2001

Condition	1997	1998	1999	2000	2001	Total
PTSD	3941	2935	2864	2707	1210	13657
Alcohol Dependence	1097	1099	1186	1366	606	5354
Anxiety conditions	1176	967	806	759	324	4032
Depression	661	745	663	626	285	2980
Impotence	126	178	269	406	225	1204
Tension headache	218	188	122	126	52	706
Adjustment disorder	144	143	138	175	79	670
Transient organic psychosis	93	130	79	16	7	325
Bipolar disorder	28	40	34	81	31	214
Panic disorder	29	50	48	46	26	199
Arteriosclerotic dementia	27	33	34	39	18	151
Personality disorder (unspecified)	33	30	27	25	10	125
Teeth grinding	16	23	29	41	11	120
Phobias	16	24	19	12	5	76
Drug dependence	19	12	15	13	6	65
Schizophrenia	16	15	15	13	2	61
Total	7890	6866	6557	6675	3018	31006

Since only claims that are service related are accepted by the DVA, these figures indicate a more accurate summary of the potential long-term mental health impact of military service. It highlights the importance of further research and establishment of prevention strategies and improved acute management processes. The above summary further reinforces the relative success in screening out applicants with recognised mental health conditions at the point of entry to the service. It indicates, however, the relative lack of success in recognising those who have a likelihood or propensity to respond adversely to the stresses and stressors inherent in service life.

Implications for the separating member

Personnel undergoing discharge on grounds of invalidity require more intensive management than those separating routinely at their own request. The immediate and extended provision of mental health care to the separating member is the most vital element in their management. A significant difference, however, between psychological/psychiatric casualties and those members who have incurred a physical illness or debilitating condition, is the degree and the duration of support received.

A separation from the military following diagnosis of a chronic or intractable mental condition leaves the member with a number of additional problems. Not only is the prospect of future employment decreased, with all the corresponding social and economic considerations, but the sufferer is likely to experience a sense of prolonged isolation from society, their family and support mechanisms.

Regardless of the logic entailed in their removal from the military environment, it is likely to be perceived as an unfair rejection and act of disloyalty by an organisation in which they had invested a significant amount of time and energy. These underlying considerations will serve to further compound the basis of the problem and significantly hamper the resolution or management of the condition.

Implications for significant others/agencies

A draft DI(G) has been prepared and governs the health assessment of ADF personnel on separation from the services. The health care provided to the member extends only to this time, however, incorporates the process by which future health care needs can be provided.

Members separating from the services classified as MEC 4 and to be discharged on the grounds of mental invalidity are to be referred to the Transition Management Service (TMS) of the DVA. There are a number of key success factors that must be incorporated in any invalidity discharge transition process. These factors include effective coordination of all key agencies, early intervention of rehabilitation as appropriate, flexibility, portability, resource efficiency and national consistency.

The purpose of the TMS is to assist the member's transition to civilian life while ensuring that appropriate on-going levels of care are available for their management. While primarily concerned with the medical management of separating ADF personnel, inclusion of mental health factors in the DVA/ Defence Links Project arose from startling figures. The number of veterans accepted for mental health related compensation claims has increased over the past ten years. The data collected by the DVA suggested a high degree of unmet mental health care needs, with a projected demand becoming an increasing component of the DVA's programs, relative to other conditions.

The preparation of the DVA Mental Health Policy has confirmed its recognition of the need to provide a seamless transition for younger veterans. It outlines four strategic directions and goals for the continuing care of these personnel (DVA Mental Health Policy). The policy is to adopt a 'whole of person' approach to mental health. It is to respond to specific health needs rather than maintain a predominant focus on PTSD. Generation of the policy will allow planning and funding for effective mental health services. The final strategic direction is to strengthen the partnerships between all participants in the mental health care process.

Families of members classified as unfit for service on psychological or psychiatric grounds are forced to accept responsibility for the ongoing financial and emotional support required by the individual. DVA studies confirm the reduced quality of life for both veterans and their respective families. Recent research conducted by the Australian Institute of Health and Welfare indicates that children of Vietnam veterans are three times more likely to commit suicide than those within the general community. Statistics such as these assume that the domestic relationship remains intact. It is possible that the family unit may be fragmented by the nature and circumstances of the underlying condition.

Generally, considerations such as these are not the direct responsibility of the ADF when a member has ceased to serve. Elements of the Australian Defence Organisation (ADO), notably the DCO, do work within their charter of delivering continued support to the immediate family. In the period prior to separation, or in the event that the member continues to serve, family support such as respite care must be a component of the overall management philosophy. Rayner (2000) strongly supports the need for recognition of the vital role played by families in the management of those with mental health concerns. Support mechanisms, including education about the conditions and their role in the care of affected individuals, are a mandatory element of strategy implementation. Although Rayner is specifically addressing PTSD, the application of his principles to the management of all mental health conditions is appropriate.

The ADF MHS cannot exist in isolation. When a member separates from the service, they continue to remain a member of the community. As a result, any attempt at strategic management of mental health problems must be in alignment with such mechanisms as the National Mental Health Strategy.

Conclusion

Mental health is considered a vital component of health and health care provision within Australia. The incidence and nature of mental health problems can be considered no less vital within the ADF. The military takes community members and may subject them to life-threatening circumstances requiring resilience and strength of character. These circumstances may expose weaknesses previously undetected or produce undesirable and long-lasting mental incapacity.

The screening of entrants to the ADF is designed to filter out those with either underlying pathology or suspect coping mechanisms. This screening is consistently applied across the three services but is recorded and reported differently. Similarly, the incidence of post-enlistment/appointment mental health morbidity is fragmented.

Special occupations and trade groups will experience stresses significantly greater than those expected in general military service. Insufficient data is available on these environments to accurately identify the demands on the individual. There is little evidenced-based practice to substantiate the focus and rigour of testing procedures applied to these specialties.

The comprehensive and effective provision of mental health care requires the formal recognition of a true, multi-disciplinary approach incorporating the professional and technical skills of generalist medical officers, psychologists, psychiatrists, nursing staff, chaplains and allied health providers. Enhanced communication processes and collective, centralised reporting mechanisms need to be devised to ensure a cohesive approach to the care which is provided.

There is no doubt that separations from the service arise from mental health issues. Due to the fragmented nature of data collection and the inability to interpret the limited information available, it is not possible to identify the full extent of any mental health contribution to a separation rate.

Recommendations

In order to enhance the efficacy and effectiveness of the mental health care provided within the ADF, it is recommended that the following areas be further developed:

- **Recommendation 4.1:** That policies and processes be established to govern the relationships of all professional disciplines involved in the provision of mental health care.
- **Recommendation 4.2:** That clinical protocols be developed to determine the manner in which mental health care is to be provided in the deployed and non-deployed environments.
- **Recommendation 4.3:** That data collection methods and instruments be developed to ensure the consistent and standardised reporting of the morbidity of mental health factors and their causal relationship to military separations.
- **Recommendation 4.4:** That evidence-based research be conducted to confirm or amend the existing criteria applied to the selection or rejection of ADF applicants.

References

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CHAPTER 5

MENTAL HEALTH RESEARCH IN THE ADF

Introduction

As reported in Australia's National Mental Health Policy (Commonwealth of Australia, 1995), one in five Australians will, at some point in their life, experience some form of mental disturbance which will significantly interfere with their functioning in life. The majority of these people will only experience one episode from which they will recover completely provided appropriate care and treatment is available.

The *ADF Health Status Report* (DHSB, 2000) highlights a number of mental health issues that are of importance for the military. It recognises that mental health plays a key role in an individual's overall health and that mental ill-health may have an effect on a member's ability to function at an optimal level.

Whilst the ADF attempts to screen the general population at enlistment, essentially they encompass the wider community and thus are not immune to the development of mental disorders. Due to the nature of work required from members of the Defence Forces, there may be times during their career where they are exposed to certain factors that may place them at risk of developing a mental illness at a later stage (Campbell, 2001; Rayner, 2000).

The ADF mental health policy needs to comply with current and future standards in mental health, both at a national and international level. In order to achieve this, a strong empirical base is required which will support current and future mental health practices within the ADF. Mental health research within the ADF therefore needs to be able to establish a balance between areas of clinical, theoretical and policy research, that can be expanded across operational and non-operational environments, whilst also considering links with general organisational factors and issues involving personnel planning.

The type of research conducted should enable information to be gathered that will examine short-term and long-term issues relevant to the mental health of ADF members. The use of applied clinical research will provide information that is directly relevant to the provision of mental health services. Theoretical research will allow the longer-term implications of mental health to be examined; and policy research will ensure any mental health data collected will be maximised and used in an optimal way.

To ensure that ADF mental health research conducted is relevant and meaningful, there is a need to integrate mental health issues in currently serving personnel with those arising in veteran populations.

Strategies for future data collection and analysis

Recruit assessment programs. The U.S. and Canadian Forces (CF) have developed a Recruit Assessment Program (RAP) after difficulties arose in determining the causes of health problems among Gulf War veterans (Hyams, 2002). As a consequence of this situation, various departments came to the conclusion that it was a necessity for accurate medical records and risk factor data to be collected, and that the U.S. military needed to collect more comprehensive data.

The RAP has been designed to allow "the routine collection of baseline demographic, medical, psycho-social, occupational and health risk factor data from all U.S. military personnel" (Hyams, 2002, p.4), starting from recruitment level. The confidential database can be accessed by Department of Defense and Veterans' Affairs clinicians, medical personnel and medical researchers on an approved basis. It provides a continuous, longitudinal record of an individual's health status from their time of enlistment through to post-discharge. The RAP will serve a number of functions including "automating enrolment into the military health care system, improving patient care and preventive medicine efforts, and providing critical care for investigations of health problems among military personnel and veterans" (Hyams, 2002, p. 4).

The development of the RAP has been viewed as a critical measure in ensuring the health of future military personnel. It has become a major health initiative, which has shown to have a large impact on health care and prevention in military and veteran populations, and has enabled health problems related to military service to be quickly identified, whilst also providing input into the development of preventive services to military personnel.

Recommendation 5.1: That standardised screening measures be identified and used as part of a RAP process. This would provide baseline information on an individual's health status on enlistment in the ADF. The development of such a measure could be a collaborative effort between the DHSB, DFPO, ACPMH and DVA. Information collected from such screening measures should be maintained in an appropriate database.

Future studies and databases. A considerable amount of data presently exists, within the ADF and DVA, that has the potential to be used to inform mental health policy, as well as program and training development; for example data on mental health services use, separation from the ADF as a result of mental health reasons and so on. Unfortunately, this data is not always readily available. In order to optimise the potential usefulness of this information, such data could be incorporated into an accessible database, which could be used for research purposes on a regular basis.

The ADF is in a position to be able to conduct longitudinal, prospectivestudies examining the development of mental health problems amongst serving personnel. All potential applicants undergo psychological and medical screening prior to their enlistment in the armed forces. Members are required to undergo regular medical examinations whilst they are employed in the services and prior to their discharge. At present, there is no routine psychological screen involved with these regular medicals and it is possible for a serving member to complete their military service with their only experience of psychology services being from their enlistment process.

The inclusion of carefully selected mental health assessments as part of the routine medical examinations would allow members' psychological health and well being to be screened on a regular basis. This would provide a comprehensive database with information in a number of areas, including: risk factors for the development of mental health problems; the effect of deployments on mental health; relationships between physical disorders and mental health; the impact of mental health conditions on a military career; and separation from the military as a result of mental ill-health.

Research of this nature could be used to aid the development of improved screening for mental health issues, as well as contributing to prevention and intervention strategies that may be designed to minimise the impact of mental health conditions on military performance.

Recommendation 5.2: That strategies be developed to ensure data collated on mental health service use, separations, compensation or sick leave is used and analysed effectively.

Recommendation 5.3: That appropriate mental health assessments, using standardised measures, be administered to all serving military personnel on a regular basis, such as to coincide with medical examinations. Information collected should be maintained on an appropriate database.

Mental health screens. Whilst the ADF has limited published research on mental health issues at present, an extensive amount of data has been collected on aspects of mental health arising from operational deployment, via the Mental Health Screen.

The Mental Health Screen was introduced in 1999 by the DFPO for ADF personnel returning from operations. It currently contains three scales: the General Health Questionnaire (GHQ; Goldberg, 1972), the Post-traumatic Stress Disorder Checklist (PCL; Weathers, Litz, Herman, Huska & Keane, 1993) and the Alcohol Use Disorders Identification Test (AUDIT; Saunders, Aasland, Babor, and de la Fuente, 1993).

At present, the information collected in the Mental Health Screen is used as a screening tool for operational debriefs and, whilst interim data has been analysed by Johnston (2000) and Deans (2001), the information at this stage has not been collated or utilised in a way that could maximise its effect, or inform policy development. There is scope for information, such as that collected in the Mental Health Screen, to be used to examine the prevalence of mental health problems in the ADF.

Recommendation 5.4: That mental health research conducted within the ADF be coordinated by a single body. Such research needs to comply with ethical requirements and an accompanying summary should be submitted at the conclusion of each project. Research papers should be collated and published on a regular basis, outlining any possible policy implications arising from that area of work.

Recommendation 5.5: Research capabilities, needs and priorities within the ADF should be investigated. Guidelines on how research is to be conducted, and where funding for projects will come from, need to be considered, so that a course of action can be developed for those projects involving extensive resources (such as longitudinal studies). Such research needs may form part of, or be based upon, the existing structure within the Defence Health and Human Performance Research Committee.

Priorities for future research

Current military mental health. GHQ data collected on ADF personnel (Goyne, 1999; Chapman, 1999) has suggested higher levels of psychopathology amongst this sample than those of the general population (Goyne, 1999). Likewise, AUDIT scores have indicated higher rates of alcohol consumption within the military population in comparison to the general community (Johnston, 2000). However, there are currently no baseline scores on these measures for ADF personnel. If such scales are to be used within the ADF then appropriate norms need to be developed, rather than relying on the civilian test norms that presently exist (Rayner, 2000).

Furthermore, an appropriate clinical assessment tool needs to be identified that suits the needs of the ADF, such as that being done by the Canadian Forces. The CF are presently looking at identifying the propensity of mental health problems within their services, as well as the resources they currently have available for treatment (Riley, 2001). In order to examine these issues, they have proposed trialing the use of the Composite International Diagnostic Interview Schedule (CIDI; Boyle, Offord, Campbell, Catlin, Goering, Lin & Racine, 1996) to conduct an epidemiological study on the mental health of CF members (Riley, 2001).

Recommendation 5.6: That research be conducted on the suitability of current psychological instruments used to assess mental health issues amongst members of the ADF. Alternative psychological measures may need to be considered in order to find an instrument that best suits the needs of the service.

Recommendation 5.7: That military norms be developed for psychological tools currently used within the ADF. If comparisons of the ADF to the wider trends of the general community wish to be made, such norms need to be developed.

Recommendation 5.8: That epidemiological studies of currently serving personnel be conducted with anonymity of participants guaranteed. Such research could investigate the nature, severity, prevalence and risk factors of mental health conditions, as well as resilience and adjustment issues arising within the ADF. Data could be collected at regular intervals providing a longitudinal study of mental health trends within the ADF. Such information could also be compared to that of the general Australian community.

Current treatment practices and barriers to seeking mental health treatment. ADF mental health surveillance is currently fragmented and ad hoc, with no standardised system in place across the three services to address mental health issues; guidance for such research is limited (Campbell, 2001; Rayner 2000). There appears to be a lack of information regarding the epidemiology of mental health conditions among ADF personnel, either as a result of high-risk situations such as operational deployment or to the general mental well-being of Australia's armed forces. Furthermore, little baseline data exists which would enable such information to be interpreted, and one of the major obstacles in collecting such data is the fear from serving members that such information may have a negative impact on their career.

Issues surrounding mental health are often associated with misinformation and stigma within our society (Commonwealth of Australia, 1995), and it appears this is even more so within the ADF community. Many serving personnel appear concerned about the impact mental health problems may have on their career progression, and it is difficult to determine how this, and other factors, may influence a member's decision to seek treatment or access health services. In order to improve mental health services within the ADF, it is important that we understand when and how members would choose to access treatment.

Recommendation 5.9: That pathways to care of mental health issues within the ADF be investigated to determine if members would seek treatment for psychiatric concerns. This could include reasons why people choose to seek treatment, why they may be reluctant to ask for help and if individuals even have the ability to recognise when they require help. This would allow barriers to acknowledging and seeking assistance for mental health services to be addressed and acted upon.

Primary prevention. It is generally acknowledged that members who have been involved in active service may be at higher risk of developing a range of physical and psychological health problems (Bennett, 1998). It is less clear whether primary prevention strategies are effective in modifying these risks.

Mental well-being within the ADF needs to consider not only the absence of clinical psychopathology, but also optimising the functional performance of individuals through mental health promotion (Campbell, 2001). At present, there are some primary preventive strategies in place within the ADF, such as psychological briefings and education provided to members pre and post-deployment, and suicide prevention training (DFPO, 2000). The extent to which briefings such as these modify the risk for future mental health problems is relatively unknown, and alternative preventative strategies could be trialed and used in conjunction with current methods.

Recommendation 5.10: That a controlled trial of preventive mental health programs (such as pre-deployment preparation) be designed. This could explore differences between minimal or no intervention, compared to classroom briefings, written material and inoculation; however, the ethical issues involved in such research would need to be considered. Issues involving mental health enhancement, as opposed to reduction of mental ill health, could also be explored.

Suicide. Suicide is an issue that continues to be a concern in mental health areas, not just within the ADF but also at a wider community level. Gisler and Sadler (2000) investigated suicide within the ADF over the period from 1985 to 2000 and found that "suicide in the ADF is indeed a significant problem" (p. 140).Whilst suicide rates within the ADF tend to be lower than the general population, it remains a leading cause of death among ADF personnel (Gisler and Sadler, 2000; DHSB, 2000).

Whilst the ADF screens applicants on enlistment for any psychiatric, medical or psychological problems, there are a number of complex issues associated with being in the ADF that may be associated with the development of a mental illness – which in turn is a risk factor for suicide (Gisler and Sadler, 2000; Commonwealth of Australia, 1995).

Whilst the DFPO (2000) has implemented a suicide prevention strategy,further research in this area needs to be considered. Such research could target identifying high-risk individuals or risk factors within the ADF, detection and prevention of suicidal and self-harming behaviour, and the development of protocols on the assessment and management of suicide-related behaviours (Gisler and Sadler, 2000).

Recommendation 5.11: That research be conducted on the identification of high risk individuals and risk factors within the ADF that would enable a comparison to the wider community. Protective factors could also be explored.

Recommendation 5.12: That a policy on conducting a psychological autopsy post-suicide or other traumatic events be implemented. Information obtained from such investigations could be used to enhance the understanding of risk factors and the appropriateness of current intervention strategies associated with suicide. This could be used to implement preventive strategies.

Standardised research protocols. There is a general opinion that early intervention following a traumatic experience may reduce the prevalence of subsequent psychiatric morbidity, however data on the efficacy of various intervention options appears to be lacking. If preventive mental health strategies are to be adopted by the ADF, it is crucial that research protocols are put in place that will assess the efficacy of such measures.

Recommendation 5.13: That the development of standardised research protocols to assess the efficacy of early intervention processes provided following exposure to traumatic experiences be considered.

Strategies to assess mental health approaches in the ADF

Collaboration between the ADF and the ACPMH. The ACPMH is currently involved with various aspects of veterans' health and has played a key role in assessing the efficacy of mental health services provided by the DVA to veterans. The recent collaboration between the ADF and the ACPMH provides an opportunity to expand current services to presently serving personnel. Many of the services available to the veteran community are identical to those available to serving personnel in terms of providers, mental health conditions and treatment options. Given the ACPMH's experience

in assessing the efficacy of mental health services to the veteran community, it would appear to be of benefit to expand their role to include the present ADF community.

Recommendation 5.14: That DFPO and DHS liase with the ACPMH regarding their existing evaluation protocols, with the aim of extending these to the evaluation of services available to currently serving personnel.

Training of ADF mental health service providers. Much of the intervention provided in mental health by primary health care providers or allied health professionals, is conducted with little specialist training in areas of mental health. The examination of competencies of current providers (both within the ADF and civilian) would allow the relationship between competencies and treatment outcomes to be investigated, and would also identify further training needs. A training package could be developed and become part of a standardised, competency-based course to be completed by ADF mental health service providers.

Recommendation 5.15: The implementation of training and competencies for ADF mental health service providers needs to be reviewed. Appropriate training packages may need to be developed, and professional, clinical supervision (as opposed to peer review) should be provided to those working in mental health related areas.

Recommendation 5.16: That DFPO and DHS liase with the ACPMH regarding their current training programs with the aim of developing further training and courses in areas relevant to military mental health, the intention being that ADF mental health service providers should complete such courses.

Research linkages and relationships

Integrated research. The collaboration between the ADF and the ACPMH provides a unique opportunity to integrate research in military and veteran mental health. The centre has a strong research background, and has the expertise and infrastructure to support a wide range of research and evaluation projects in military-related mental health.

Recommendation 5.17: That DFPO and DHSB support the collaboration with the ACPMH and develop an integrated research agenda in the area of veteran and military mental health.

Coordinated research. Current ADF research in health and psychology falls among a number of different sections including the Psychology Research and Technology Group (PRTG), the Directorate of Strategic Personnel Policy and Research (DSPPR), and the Defence Science and Technology Organisation (DSTO). At present there is little documented research within the organisation that has been conducted on mental health issues. The focus until now has been predominately on assessment and recruitment issues, operational effectiveness and human factors, and wider personnel issues affecting the broader military organisation.

Liaison between research sections is not always optimal, and as aspects of military mental health may be affected by personnel issues or operational effectiveness, for military mental health research to be effective, it is important that all relevant parties are kept informed and, where appropriate, be provided with the opportunity to become involved.

Recommendation 5.18: That a military mental health research group be formed. Such a group could involve representatives from key areas such as PRTG, DSPPR, DSTO, the ACPMH and DVA, and could be involved with coordinating and overseeing research conducted on mental health issues within the military.

Both the ADF and the ACPMH have strong international links with other defence forces and research organisations, and these should continue to be utilised. Research developments in the ADF and the other nations of The Technical Cooperation Panel countries (USA, UK, NZ, CA) relating to military mental health will remain vital in the ongoing development and provision of mental health services to currently serving personnel and the veteran community as well as assisting interoperability.

Recommendation 5.19: That research links between allied forces be expanded to involve issues involving military mental health. This would allow a comparison of the mental wellbeing of defence members of various nations to be obtained, as well as provide a standard of practice for the provision of mental health services across the wider defence force.

Conclusion

Whilst research on mental health issues within the ADF and other military forces is presently limited, there appears to be a wide scope to expand and develop these areas to provide an ADF military mental health policy that will address the needs of the currently serving population, as well as encompass issues affecting the veteran community. In order to meet these needs, and to provide mental health services of a high standard, empirical research is vital and a number of potential research areas have been identified within this chapter.

It is crucial that research in the area of military mental health is ongoing and that all Defence members are aware that mental health issues arise in operational and non-operational environments. Essentially, if optimal performance and functioning is to be achieved from members within the ADF, then the mental health of serving members must be considered a priority.

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