



GOVERNMENT RESPONSE TO THE MENTAL HEALTH CARE IN THE ADF AND TRANSITION TO DISCHARGE

Section One – Overview

The Government is committed to ensuring that the very best mental health support is available for Australian Defence Force (ADF) personnel and the ex-service community.

Professor David Dunt was commissioned to conduct an independent review of the effectiveness of ADF mental health care and programs, and support through the transition process from Defence to the Department of Veterans' Affairs (DVA).

The review's focus was to benchmark the current ADF mental health support services against best practice and administrative perspectives, including the transition process to DVA and the extent to which mental health services meet the needs of serving and transitioning ADF members.

Professor Dunt considered that the introduction of the ADF Mental Health Strategy in 2002 was far-sighted and that it compares favourably with similar strategies in Australian workplaces and other military forces, which it surpasses in many ways.

Nevertheless, Professor Dunt's benchmark review necessarily highlights the gaps in the delivery of mental health services, and he makes 52 recommendations to reform and enhance the delivery of ADF mental health programs and Defence and DVA transition services.

Defence has agreed to 49 of the 52 recommendations and partially agreed to three recommendations. Funding of 83M has been allocated over the next four years to start a major program of reform that will address the gaps identified, including providing improved mental health governance and policy, an enhanced mental health workforce, improved mental health training for ADF personnel and providers, enhanced prevention strategies including better research and surveillance, enhanced mental health rehabilitation and transition services, greater involvement of families in the mental health of ADF members, and better facilities from which mental health services will be delivered.

Defence will implement a comprehensive plan to address the Dunt Review recommendations that focuses on 10 major goals:

- **Improving mental health governance:**

Example: Increasing oversight of mental health services and the mental health strategy including the development of a comprehensive e-health data management and record keeping system.

- **Improving mental health policy:**

Example: Breaking down stigma by demonstrating that Defence's goal is to treat and rehabilitate wherever possible, and that discharge on health grounds is the last resort.

- **Enhancing the mental health workforce:**

Example 1: Increasing the mental health workforce at local levels to improve service delivery by significantly increasing access to clinical services and multi-disciplinary teams.

Example 2: Establishing an ADF National Centre for Defence Mental Health where residential programs will better address the special needs of younger veterans and provide early intervention and treatment, as well as providing tele-psychiatry treatment and supervision capabilities.

- **Improving mental health training:**

Example: Augmenting regional mental health teams to provide mental health literacy training to ADF members, engage in preventative work and provide regional outpatient treatment programs.

- **Prevention strategies:**

Example: Expanding the BattleSMART (Stress Management and Resilience Training) program to improve the psychological resilience of ADF members and their ability to function competently under stress and recover from the impacts of exposure to trauma and adversity.

- **Enhanced research and surveillance:**

Example 1: Introducing an electronic health (e-health) record keeping system to provide robust surveillance of mental health issues and trends, while innovative e-counselling and tele-psychiatry options will further broaden the opportunity for ADF members to seek mental health care.

Example 2: Ongoing collaboration and research with the Department of Veterans' Affairs, the Centre for Military and Veterans' Health and the Australian Centre for Posttraumatic Mental Health.

- **Rehabilitation and return to work programs:**

Example: Enhancing the ADF Rehabilitation Program through better case management by medical officers and increasing the number of rehabilitation coordinators.

- **Transition services:**

Example: Ensuring the transition service arrangements adequately provide seamless transition from military to civilian life for individuals with mental health issues as well as scoping ways to remain in contact with transitioning members and ensure that all personnel are recognised for their service.

- **Families:**

Example: Better engaging families in recognition of the crucial role they play in the overall health and wellbeing of ADF members and offering the opportunity for families to be engaged in mental health support programs.

- **Facilities:**

Example: New and improved facilities for enhanced delivery of mental health services and easier access to care by ADF members and involvement by their families in support programs.

Section 2 - The ADF's Mental Health Strategy

1. Recommendation 2.1: The Directorate of Mental Health needs to be fully staffed and core positions need to be established as tri-service rather than on loan by the Single Services.

Government Response: Accepted. In order to implement the significant reforms of the Dunt Report the workforce within the Directorate of Mental Health will be significantly enhanced. It is planned that an additional nine positions will be created to ensure that all six initiatives of the mental health strategy have the required workforce. This will increase the capacity of the Directorate of Mental Health to conduct resilience training, implement post deployment personnel management programs, conduct program evaluation activities, and engage families. The restructuring and staffing of the Directorate of Mental Health will be achieved by January 2010.

2. Recommendation 2.2: An oversight group to the Directorate of Mental Health should be established to consist of senior Defence health, Single Service health and Defence personnel as well as non-Defence clinical and academic experts. The purpose of such a group would be to sustain the strategic direction and delivery of the Mental Health Strategy. (Same as Recommendation 3.8).

Government Response: Accepted. This recommendation contributes to the goal of improving mental health governance in Defence by ensuring that there is a mental health representative on the Joint Health Command Strategic Policy Advisory Group. The joint Health Command Strategic Policy Advisory Group will be in place by the end of 2009.

3. Recommendation 2.3: The Mental Health Strategy needs further development for it truly to be a Strategy rather than a small number of specific programs as at present.
 - It should specifically include components in resilience training (including stress inoculation, mental health first aid as well as personal and relationship life skills), mental health literacy and bullying.
 - The Strategy should be evidence-based to the greatest extent possible and the innovative components should be rigorously evaluated.
 - Attention to presentation (marketing) of the revised Mental Health Strategy so as to have maximum impact on ADF members will also be important.

Government Response: Accepted. Joint Health Command will develop the next evolution of the ADF Mental Health Strategy consistent with the Dunt Review recommendations. Underpinning this process will be a robust and effective e-health data collection system to monitor mental health trends. The next iteration of the ADF Mental Health Strategy will be released by July 2010.

Section 3 The delivery of mental health services in the ADF

Primary care on bases

4. Recommendation 3.1: Psychology Support Sections on bases should combine to form teams with health professionals providing mental health care services in medical centres/hospitals and be renamed Mental Health and Psychology Support Services (MHPSS).

Government Response: Accepted. The mental health workforce will be enhanced by the full integration of the Psychology Support Sections into the regional garrison health care delivery areas, while still maintaining their organizational psychology tasking. This will allow the formation of multi-disciplinary teams in order to deliver best practice care. These services will be formed and located within Defence health facilities by July 2010.

5. Recommendation 3.2: Social workers in DCO can have an important role in the delivery of primary mental health care services where family issues are involved. They should form part of the proposed multidisciplinary mental health team on base. Their services should be available not only to families of members but members themselves where family issues are involved. (Same as Recommendation 11.3).

Government Response: Accepted. The mental health workforce will be enhanced by the full integration of health professionals, including clinical social workers, into the regional garrison health care delivery areas. This will allow the formation of multi-disciplinary teams in order to deliver best practice care. There will be further enhancement of the interaction with the Defence Community Organisation.

6. Recommendation 3.3: The role of chaplains in primary care mental health services is supported.

Government Response: Accepted. Chaplains play an important supporting role for mental health services, given their role in deploying forward with, and their wide acceptance by, ADF personnel and are seen as being essential as primary health care services. They assist in the identification of personnel with mental health problems and provide pastoral care.

Secondary care in regions

7. Recommendation 3.4: The proposal to create tri-service Regional Mental Health Units (RMHUs) can be supported.

Government Response: Accepted. Regional mental health units are an important part of enhancing the mental health workforce and will be created to provide mental health literacy training to members, be engaged in preventative work and provide regional outpatient mental health programs. The units will include new and improved facilities for enhanced delivery of

mental health services and easier access to care by ADF members and involvement by their families in support programs.

8. Recommendation 3.5: An important part of the roles of clinical specialists in RMHUs is to visit bases to support primary care mental health practitioners particularly through participation in 'shared care' arrangements and some direct provision of care.

Government Response: Accepted. The Regional Mental Health Units will provide outreach to other health professionals in the regions by assisting with complex cases, acting as a specialist referral agency, as well as providing clinical supervision, training, and support.

Tertiary care nationally

9. Recommendation 3.6: The proposal to establish a tertiary-level, triservice inpatient mental health ward within a general hospital facility can in principle be supported but should have lower priority than the rapid and sustained development of high quality primary mental care facilities on bases.

Government Response: Accepted. The ADF Mental Health Center will contribute to the goal of enhancing the mental health workforce. This centre will offer group based residential programs for ADF members, addressing the special needs of younger veterans and provide early intervention and treatment. Services will include outpatient programs and specialist professional training programs. It will become the hub of tele-psychiatry services for Defence and provide supervision to mental health professionals nationally, as well as have the capability to support deployed health professionals.

National planning and operations for mental health services

10. Recommendation 3.7: The Directorates of Mental Health and Psychology should merge to become the Directorate (or Branch) of Mental Health and Psychology (DMHP) with an SES Band 1 level Director to lead this combined entity.

Government Response: Accepted. A review is being conducted within Joint Health Command to enable a restructure that reflects the priority given to mental health in the Dunt Review. This review will be completed by the end of 2009.

11. Recommendation 3.8: As previously proposed (Recommendation 2.2) an oversight group to the Directorate of Mental Health should be established to consist of senior Defence health, single Service health and Defence personnel staff as well as non-Defence clinical and academic experts. The purpose of such a group would be to sustain the strategic direction and delivery of the Mental Health Strategy.

Government Response: Accepted. This recommendation contributes to the goal of improving mental health governance in Defence by ensuring that there is a mental health representative on the Joint Health Command Strategic Policy Advisory Group.

12. Recommendation 3.9: The Psychology Support Group should be renamed the Mental Health and Psychology Support Group (MHPSG) and should become multidisciplinary in nature.

Government Response: Accepted. The mental health workforce will be enhanced by the full integration of the Psychology Support Sections into the regional garrison health care delivery areas, while still maintaining their organizational psychology tasking. This will allow the formation of multi-disciplinary teams in order to deliver best practice care.

Section 4 The ADF mental health workforce – staffing and training issues

13. Recommendation 4.1: Additional staff should be allocated to the mental health arena accompanied by an increase in APS positions in JHC. Any reallocation under existing staffing caps will see the imposition of deficits in other areas of health care delivery. An overall increase in the Mental Health budget is also necessary in order to deal with critical staffing issues.

Government Response: Accepted. The government is aware of the need to increase the number of regional primary mental health care professionals within Defence and will provide significant funding to allow increased contract staff in all areas of Australia.

14. Recommendation 4.2: Recruitment strategies for Contract Health Practitioners (CHPs) need to offer pay and conditions more attractive to CHPs. They should aim to recruit GPs with a demonstrated interest in mental health.

Government Response: Partially Accepted. Defence is a competitive employer for CHPs in respect to pay and conditions however additional emphasis will be given to mental health training and additional mental health training programs will be introduced.

15. Recommendation 4.3: The use of third party providers (and specifically VVCS) should be considered as providers of mental health services both on and off base.

Government Response: Accepted. Defence health staff can refer to a number of external mental health providers in their regions. There is an agreement for Services with VVCS – Veterans and Veterans Families Counselling Service - that allows for a close working relationship between Defence and the Department of Veterans' Affairs. This relationship facilitates the introduction of serving veterans to the range of DVA support services and allows referral to professionals experienced with veteran populations. Other third party

providers that are currently utilised include clinical psychologists and psychiatrists, both on and off base. This integrated workforce model will contribute to the goal of enhancing the mental health workforce.

16. Recommendation 4.4: Options such as tele-psychiatry have obvious attractions for the provision of mental health care in remote settings and could operate out of the proposed tertiary level in-patient facility or a RMHU– see Section 3.5.

Government Response: Accepted. The provision of mental health care in remote areas and deployed settings is a priority, in order to ensure the ongoing well being of ADF members. The ADF Mental Health Center will research and evaluate options for remote delivery of mental health care and will become the hub for tele-psychiatry. An initial scoping study for the roll out of tele-psychiatry options will be completed by the end of 2009.

17. Recommendation 4.5: Psychology assets should be more efficiently deployed by greater use of non-psychologists where this is possible and the redesign of post-deployment psychological screening so as to increase the availability of psychologists on base for primary mental health care.

Government Response: Accepted. The formation of multi-disciplinary teams through the integration of Psychology Support Sections into garrison health care delivery will support the prioritisation of mental health as outlined in the Dunt Review.

18. Recommendation 4.6: A position should be established within the DMH for a relatively junior medical officer to liaise with medical officers in the ADF and promote their involvement and training in primary mental health care.

Government Response: Accepted. The contracting of a medical practitioner to one of the key national coordinator positions with the Directorate of Mental Health will be a priority.

19. Recommendation 4.7: Pastoral care training for chaplains should be increased.

Government Response: Accepted. Mental health care is part of the chaplain's role within the ADF. A review will be conducted of Pastoral Care training to ensure that mental health issues area adequately addressed.

20. Recommendation 4.8: Expanded initial induction and continuous professional development programs are necessary for medical officers, psychologists and other health personnel aimed at substantially increasing the proportion of mental health staff who are competent to deliver cognitive behavioural therapy, care coordination, and the

management of non-complex mood and adjustment disorders. Goals for the proportion of staff attending these courses should be set and progress towards these goals should be monitored annually. Appropriate release and travel arrangements will be necessary for this to occur.

Government Response: Accepted. Improving mental health care training is a critical step in achieving better quality of care for ADF members and will act as an incentive to attract health professionals. Innovative training modalities will be utilised to provide Defence health professionals with techniques reflecting best practice in assessment and treatment. Innovation will be achieved through collaboration with national centers of excellence in mental health.

21. Recommendation 4.9: AMHOO should be rolled-out - all mental health staff about to deploy should be required to attend.

Government Response: Accepted. As part of the goal to improve mental health training for the workforce, the Defence Acute Mental Health on Operations (AMHOO) course will be delivered to all deploying health professionals. This course specifically addresses management of acute military mental health issues on operations.

Section 5 Screening for mental health problems – RtAPS and POPS

22. Recommendation 5.1: The POPS should retain its present form with additional resourcing so that follow-up and referral for members with possible problems can occur. This requires adequate and timely access to secondary care as well as primary care level mental health professionals.

Other desirable new features of the POPS would be an additional brief involving families and an appropriate record system to monitor that follow-up and referral is happening.

Government Response: Accepted. The screening processes for mental health problems of ADF members, including the Post Operational Psychological Screen (POPS), will be reviewed in May 09 by community and Defence mental health experts, and the findings used to inform the screening processes conducted by Defence. Defence accepts the importance of families in reintegration after deployment, and will explore options for their increased involvement

23. Recommendation 5.2: It is proposed that only the ‘briefs’ components of the RtAPS be retained. The psychological screen and one-on-one counseling components should be discontinued. The group brief should involve members’ families as well as members and take place on an occasion back in Australia which has both educational and social purposes (eg meeting/talks followed by a BBQ). A suitable name for it would be the Short Returning to Australia Reengagement Program (SRARP).

Resources on base should be increased so that members with early post-deployment problems should have adequate access in the first instance, to primary care level mental health staff.

It is possible to consider that a full second screen could return in the future. It would need to be demonstrated however that one screen has positive benefits for members, that mental health services on base are fully staffed and that there are additional staff to both conduct and properly follow-up two post-deployment screens.

Government Response: Partially Accepted. Subject to further examination of post operational psychological care procedures, psychological screens and individual interviews will continue during the Return to Australia Screen. These procedures will be reviewed and this will occur at a major think tank to be conducted by the Centre for Military and Veterans Health. International experts, military leaders and mental health specialists will provide input into the most effective model for conducting mental health screens in the ADF. The importance of families in reintegration after deployment is acknowledged, and options will be explored to increase the involvement of families. Finally, the ADF's mental health workforce will be increased to improve access to primary mental health care.

Section 6 Military culture and mental health

24. Recommendation 6.1: Pre-deployment briefings and other annual briefings should include education and training in mental resilience. As these programs are innovative in nature, they need to be evaluated.

Government Response: Accepted. As a key prevention strategy, the ADF is establishing a comprehensive resilience training program called BattleSMART (Self Management and Resilience Training). This training is evidence based and Australia is a world leader in its delivery. An evaluation of the program is currently being developed to allow it to be delivered to all ADF members at strategic points in their military careers. This will further enhance the psychological component of current pre deployment briefings.

25. Recommendation 6.2: Recruit schools should include education and training in mental resilience. Resilience training should also be introduced in promotional and officer courses so that this can later be communicated to lower ranks. Again, as these programs are innovative in nature, they need to be evaluated.

Government Response: Accepted. Resilience training for ADF recruits is currently being delivered. This training is the core of the BattleSMART training program. The training is evidence based and Australia is a world leader in its delivery. An evaluation of the program is currently being developed to allow it to be delivered to all ADF members at strategic points in their military careers.

26. Recommendation 6.3: All training, promotional and officer courses should include sessions on mental health literacy and bullying. The presentation of these topics is challenging and needs to move beyond front of classroom 'briefs' to be more scenario-based and involve role playing. It should not be so short and embedded among large numbers of briefs to make no impression on members.

Opportunities for even further strengthening Defence Policy in Discrimination and harassment through military discipline or other avenues should be explored.

Government Response: Accepted. To enhance the goal of preventing mental health issues Defence will support the expansion of mental health literacy training initiatives that will increase the general understanding of the impact and appropriate management of mental health conditions. Currently there are innovative and interactive mental health literacy programs in Defence in the areas of suicide prevention and alcohol tobacco and other drugs. The programs will be expanded to address other important mental health concerns and the regional mental health units will ensure that they are delivered regionally. The additional online training will be available by the end of 2009 and training programs rolled out to the regions across 2010.

27. Recommendation 6.4: Paramedics and medical clerks working in Defence medical services should be educated and counselled about the importance that members place on being able to consult doctors in confidence. If education and counselling is insufficient, they should not be able to continue working in Defence health centres, cautioned or disciplined. (Same as Recommendation 7.3).

Government Response: Accepted. Health providers in Defence are trained in the sensitivity and privacy of members' health information. This training will ensure that there is regular reinforcement, especially for Paramedics and medical clerks, of health care facilitators and providers' legal and moral obligations in maintaining the privacy of members. The enhanced training and quality assurance measures will be in place by the middle of 2010.

28. Recommendation 6.5: For a variety of reasons, Reservists are more likely to experience higher rates of mental health problems post-deployment and experience more difficulties in their recognition and treatment. There should be the same expectation that Reservists attend post-deployment screening and follow-up treatment, if problems are detected, as regular members.

Government Response: Accepted. Increasingly Reservists are being asked to deploy on operations and therefore are an important population for prevention programs. The Government recognizes the unique needs of Reservists and therefore is committed to developing a range of innovative approaches to ensure the successful return and reintegration of Reservists following deployments. In particular, a web-based electronic health record would significantly enhance support to Reservists by allowing access to trusted health information and their own health record.

Section 7 Privacy, disclosure and sharing of mental health information

29. Recommendation 7.1: The common multidisciplinary mental health service proposed for what are now separate mental health services should help to promote the sharing of health information among mental health practitioners – see Recommendation 3.1. A common clinical record shared by doctors, psychologists and others is a very important advantage of a common mental health service.

Government Response: Accepted. The recommendation contributes to the goal of developing improved mental health policy for Defence. A policy directive addressing new procedures for sharing of health information to allow effective mental health case management has been developed and is currently being implemented within Defence. An electronic health record will allow real time sharing of health information in the multidisciplinary team. Furthermore, the electronic health record system being developed will be interactive with external providers including veteran and national health systems to ensure a whole-of-government approach.

30. Recommendation 7.2: Policy to overcome the non-sharing of health information, as expressed in the recent amendment to DI(G) 16-20 Paragraph 9 and Health Directive 810 should be implemented. In the event of the common multidisciplinary mental health service not proceeding, implementation of this policy should be independently monitored by 12 monthly audits against agreed benchmarks for the next three years. Redress procedures will need to be put in place if benchmark levels are not reached.

Government Response: Accepted. A new policy specifically addressing the sharing of health information among primary care health professionals for mental health case management has been developed and disseminated. A coordinated approach to clinical management by a multidisciplinary team is essential to maximise the opportunity for members to be rehabilitated, to be retained, and to provide effective service. Furthermore, an electronic health record will allow real time sharing of health information in the multidisciplinary team.

31. Recommendation 7.3: (re-presented, same as Recommendation 6.4). Paramedics and medical clerks working in Defence Health Services should be educated and counselled about the importance that members can consult doctors in confidence. Failing that, they should not be able to continue working in health services or disciplined for breaches in Defence medical services.

Government Response: Accepted. Health providers in Defence are trained in the sensitivity and privacy of members' health information. This training will ensure that there is regular reinforcement, especially for Paramedics and medical clerks, of health care facilitators and providers' legal and moral obligations in maintaining the privacy of members. The enhanced training and quality assurance measures will be in place by the middle of 2010.

Section 8 The Medical Employment Classification (MEC) system and Mental Health

32. Recommendation 8.1: Guidelines to guide the application of the MEC system should be developed so as to better define what levels of present or possible future severity of common illnesses (particularly mental illnesses) are compatible with deployability, as determined by their ability to tolerate the withdrawal of medical or care support under operational conditions over a 21 or more day period.

The guidelines would be based on, and further extend the Medical Risk Assessment Framework set out in HD 282. The guidelines would be indicative and take into account the clinical discretion in decision-making of the individual doctor assessing an individual member and their circumstances.

Government Response: Accepted. The Military Employment Classification system is currently under review and Defence will ensure that mental health issues are considered, especially the extended period often required for recovery from mental illness. Joint Health Command is currently reviewing policy in the areas of PTSD and depression to provide better guidance to doctors and assist them to conduct effective risk assessments for a military environment. This new policy guidance will be published by the middle of 2010.

33. Recommendation 8.2: The proposed strategy for the development of a policy on the use of anti-depressant medication on deployment is supported.

Government Response: Accepted. The need for an effective policy that addresses the occupational impact of anti depressant medication use for Defence personnel, especially in deployed settings is acknowledged and reaffirmed. This recommendation will contribute to the goal of improving mental health policy. This policy will be in place by December 2009.

34. Recommendation 8.3: The concept of differentiating deployment into levels should be explored to investigate if it is possible to increase the proportion of members able to deploy at acceptable levels of risk.

Government Response: Accepted. The deployment of members is being considered as part of the current review of the Medical Classification System. The review will be completed by 2010.

35. Recommendation 8.4: The recent trial by the Chief of Army for members no longer deployable to continue in the ADF in nominated roles such as training has value and should be continued.

Government Response: Accepted. Occupational and vocational rehabilitation is currently available through the ADF Rehabilitation program for both physical and mental health

injuries. This program which maximises members' opportunities to return to work as non deployable personnel is supported with respect to mental health and retention needs.

Section 9 Rehabilitation in the ADF and Mental Health

36. Recommendation 9.1: The current occupational health model in relation to members with chronic mental conditions needs further development. This will further involve not only the member and the care team, but also their commanding officer.

Government Response: Accepted. The ADF Rehabilitation Program is a comprehensive program addressing occupational and work-based rehabilitation. The return to work programs assist members to remain in the ADF and are important in addressing issues arising from increased injuries and mental health problems. By mid 2010, Defence will introduce training for commanders, career managers, and health professionals that increases the awareness of mental health issues in rehabilitation, to allow them to effectively utilise the ADF Rehabilitation Program. Defence has already introduced policy that promotes more effective clinical case management and will be further supported with innovative training.

37. Recommendation 9.2: Support for alternative employment in the member's unit, or elsewhere in their base depends on the mental health literacy of officers as well as other ranks. Rehabilitation for members with chronic mental illnesses including the desirability of alternative employment should therefore be a component of the mental health literacy training in promotional and officer training courses, as set out in Section 6.

Government Response: Accepted. Mental health literacy or an understanding of the issues surrounding mental health issues is fundamental to managing individuals with a mental health condition. It is important that ADF personnel at all levels in the organisation responsible for managing members with chronic mental health conditions have a sound understanding of the impact of such conditions on the individual. Defence will expand current mental health literacy programs.

38. Recommendation 9.3: Participation in on- or off-base rehabilitation programs aimed at returning the member to work is also important. These programs realistically may need to prepare the member for return to work outside the ADF. The principles of rehabilitation (a graduated return to military life which combines both treatment for mental illness and military training) at the former Military Training and Rehabilitation Unit (MTRU) in the UK is worthy of further study.

Government Response: Accepted. A scoping study will be conducted to explore alternative models for delivery of rehabilitation both in Defence and civilian environments. The goal will be to develop an innovative approach that meets the unique needs of serving military personnel and their particular conditions. This study will be completed by the middle of 2010 and an options report produced.

39. Recommendation 9.4: On-base 'rehabilitation platoons' stigmatise their members and, as a practice, should be discontinued.

Government Response: Partially Accepted. Rehabilitation platoons at the unit level have the potential to stigmatise members. Defence is examining alternative models which will allow ADF members to maintain their military identity and social support networks without stigma. These models will utilise the ADF Rehabilitation program model of occupational and workplace-based rehabilitation. The ADF Rehabilitation Program enables members who are on a graduated return to work program to retain links with their mates and their unit, thus contributing to an easier transition back to the workplace and full-time duties.

Section 10 Transition from the ADF

40. Recommendation 10.1: The ADF and DVA should have joint responsibility for a comprehensive transition service that works closely with the ADF Transition Centres and extends to at least 12 months post-discharge. It should resolve the duplication in services now being offered by the IPSS and TMS. ADF should fund pre-discharge activities and DVA post-discharge activities within this joint responsibility.

Government Response: Accepted. Defence and DVA are working collaboratively to deliver a seamless transition service that ensures all reasonable assistance and support is available and utilised by members and their families preparing to transition to civilian life.

41. Recommendation 10.2: The Lifecycle pilot adds value to existing programs (IPSS/TMS) in improving staff training and support. If successfully evaluated it should be rolled out nationally.

Government Response: Accepted. The Lifecycle Transition Mental Health and Family Collaborative is an initiative currently being trialled in Townsville, Queensland. The aim of the initiative is to establish more effective mental health and family support services for medically separating personnel at risk of, or experiencing, mental health problems. Outcomes and recommendations from the trial will inform further development of the enhanced transition support service. The Government notes that the timetable for the evaluation of the Lifecycle pilot in Townsville is in mid 2010.

42. Recommendation 10.3: In principle families should have an involvement in Transition programs. This could be at the Transition Seminars involving the Stepping Out program that may need some redesign.

Government Response: Accepted. The Government recognises the importance of families in the Defence transition services and will explore strategies to increase family involvement in the transition service including ADF transition seminars and the Stepping Out Program.

43. Recommendation 10.4: It is important that members leaving the ADF with mental health (or other problems) are fulsomely acknowledged for their contributions to the ADF, particularly so as their health had deteriorated while they were in the ADF. This could take the form of a letter of thanks from CDF or Passing out Parade.

Government Response: Accepted. ADF members who are separating are to be pro-actively engaged and treated with care, consideration, and compassion. The separation process is to be as uncomplicated and stress free as possible and include formal acknowledgment of the member's contributions to the ADF.

44. Recommendation 10.5: A Keeping in Touch program post-discharge with joint responsibility by the ADF and DVA extends this healing process. In doing so, it is likely to make an important contribution to the proactive management of any emerging mental health problems.

Government Response: Accepted. As mental health issues may not surface for some period after separation from the ADF a robust program that encourages contact with Defence and veteran organisations may serve to assist the better management and early detection of emerging mental health problems. Defence and DVA are currently exploring this issue.

Section 11 Mental health and families in the ADF

45. Recommendation 11.1: At a broad conceptual level, the ADF needs to welcome the member's family as well as the member into the broad 'Defence family'. Acknowledgement of this in itself is important.

Government Response: Accepted. Families play a crucial role in the overall health and wellbeing of ADF members and, wherever possible, Defence will ensure that families are engaged and have the opportunity to be involved in mental health support programs. Funding for families will enhance the mental health component of programs already implemented by Defence and explore new options for greater involvement of families in the mental health support continuum.

46. Recommendation 11.2: More concrete expressions of this acknowledgement are necessary.

These could include participation by families in post-deployment readjustment program (SRARP (see above) and POPS) and pre-deployment briefings (as occurs in the US) as well as transition activities (see Section 10). It could also include attention to family impact on postings and post-deployment exercises and training activities that require members to spend further long periods of time away from their families.

Government Response: Accepted. The commitment to the importance of families will be demonstrated by the increased engagement of families across a member's service career

including initial employment, periods of deployment and transition processes. Additionally, Defence will support further development of a family friendly culture within Defence.

47. Recommendation 11.3: (re-presented, same as Recommendation 3.2). Social workers in DCO can have an important role in the delivery of primary care mental services where family issues are involved. They should form part of the proposed multidisciplinary mental health team on base. Their services should be available not only to families of members but members themselves where family issues are involved.

Government Response: Accepted. The mental health workforce will be enhanced by the full integration of health professionals, including clinical social workers, into the regional garrison health care delivery areas. This will allow the formation of multi-disciplinary teams in order to deliver best practice care. There will be further enhancement of the interaction with the Defence Community Organisation.

Section 12 Mental Health research and surveillance in the ADF

48. Recommendation 12.1: The conduct of a prevalence survey of mental health conditions in the ADF should be a high priority. Different options exist and the aim should be to choose the one that best produces robust, useful data and at reasonable cost. If online methods prove suitable for collecting valid and reliable data, they have many obvious advantages.

Government Response: Accepted. The collection of prevalence data will enable the capture of mental health information to inform future priorities of mental health programs. The Government will support Defence to explore options for adapting current research programs to meet this need. This will be assisted by the introduction of an electronic health record.

49. Recommendation 12.2: The ADF's strong commitment to development and evaluation of innovative programs should continue. New programs for members returning from deployment to forward bases with adjustment problems and traumatic stress symptoms should be a high priority for development and evaluation.

Government Response: Accepted. The ADF has developed a broad range of innovative mental health programs within the ADF Mental Health Strategy. The two proposed National Coordinators positions in the areas of Operational Mental Health and Posttraumatic Mental Health will allow the further development and evaluation of programs, particularly for members returning from deployment.

50. Recommendation 12.3: The Mental Health Research and Surveillance Advisory Committee has made an important contribution to the Directorate of Mental Health. It should be reestablished as a subcommittee or group of the oversight group proposed for the Directorate of Mental Health.

Government Response: Accepted. Defence will continue to place priority on mental health research, and will reinvigorate the Mental Health Research and Surveillance Advisory Group. The Mental Health Research and Surveillance Advisory Group includes recognized national specialists in the area of mental health, command representatives, Department of Veteran Affairs representation and Joint Health Command mental health research staff.

51. Recommendation 12.4: The PRTG has done valuable work e.g. the development of the Electronic Psychology Records and Information System (EPRIS). It will increasingly focus on the new directions for mental health taking place the ADF such as the further development and evaluation of the Mental Health Strategy and the delivery of services in multidisciplinary mental health teams.

Government Response: Accepted. There is an ongoing requirement for mental health and psychological research within Defence. An electronic health data and management system will be developed that will enhance the ability of Defence to conduct mental health and psychology research. Furthermore, the development of the common electronic health record shared by all health professionals will allow real time sharing of health information in the multidisciplinary team.

52. Recommendation 12.5: The decision by COSC to investigate commercial off-the-shelf e-health products to provide a fast-track interim solution to the lack of a comprehensive health information system can be strongly supported. The products should possess the functionality equivalent to what exists elsewhere in the community. This should include occasions of service, diagnosis, quality of life and other psychometric measures of symptom severity at secondary levels of mental health care.

Government Response: Accepted. An electronic e-health system is being developed that will meet world best practice standard. The introduction of this system will have a wide reaching impact; allowing seamless access to health information for all health workers, both within and external to the ADF. Communication within the multi disciplinary teams will be greatly enhanced and case management will be facilitated. Research will be enabled through the development of easily accessed databases.

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