DEFENCE PROCESS QUESTIONS

1. **Information**

a) What information is provided on possible psychological effects of combat and of specific experiences within combat (eg dealing with corpses, or severe injuries; fears of chemical or biological weapons)?

b) If there is a lower level of safety standards and a lower level of accurate information about exposure to various events if Australian troops are commanded by another force – eg UN or US – what are the main differences in such standards? What provision is made by Defence for obtaining accurate and detailed information on all Australian personnel serving in such situations?

c) Do you believe that personnel have sufficient information on possible effects of different events to be able to make accurate statements about their experience, especially if making claims for ill-health?

RESPONSES

1.

a) The pre-deployment education provided to ADF members deploying on operations includes a number of discrete modules that can be included when appropriate, including body handling and the psychological issues involved in operations in an environment where there is a threat of chemical or biological weapons.

b) Through the work of the Australia, Britain, Canada and America Standardisation Program and the Air Standardisation Coordinating Committee, safety standards and occupational health surveillance have essentially been standardised amongst the participating nations; with New Zealand having observer status. The UN doctrine generally reflects US standards but, depending on the nations involved, implementation of such doctrine may be sub-optimal. If a particular threat is identified but does not appear to be addressed appropriately within the area of operations, the ADF will deploy subject matter experts for as long as is required to ensure that appropriate standards are maintained.

c) ADF personnel receive detailed health threat assessment briefings prior to deployment that provide sufficient information about the risks and possible consequences of different hazards.

2. **Provision of Health Services in ADF.**

a) It has been stated that provision of health services to the ADF has been outsourced[1]. Can you advise if this is the case and how it was determined that external service providers would have the requisite skills and experience to meet the multiple needs of the ADF?

b) In what ways can you guarantee the input of appropriately qualified and experienced health personnel to planning for deployment, provision of services during operations, and effective follow up after deployments?

c) Would you agree with Submission 5 that 'operational health capability' appears to have been run down, and that some knowledge and expertise 'is required to be an ADF core function'.[2]

d) The processes by which all three services can obtain updates on the health of personnel since the last annual check require the individual to have a clear awareness of his health status. Also, such updates appear to occur only when deployment is possible[3] and therefore disease or injury with limited symptoms could progress unchecked during periods of peace, for at least twelve months.

Are there any changes planned to the current processes for determining readiness for deployment, or even being fit for peacetime service (aside from entering data on compensation claims and payments)?

e) The 1997 ANAO audit of Defence health stated that the cost of providing health care was about three times that of providing health care to the community[4].

i) Have the changes implemented as a result of that audit and other reviews led to a situation where the quality of care provided has decreased, although the costs may have declined?

ii) Do your performance standards or key indicators for health services include reduction of all possible costs?

f) What is your performance indicator for cost effective quality health care (eg no known cases where failure to provide procedures on basis of cost resulted in adverse health outcomes)? Have you met the standards that have been set?

g) Some submissions have stated that there is also a need for better standards in non-deployment health care, referring to matters such as unnecessary exposures to various substances[5]. Given long established awareness of possible adverse effects of some of these substances, can the ADF be seen to be reactive rather than proactive in protecting the health of personnel?

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[1] Submission 5, Regular Defence Force Welfare Association, p.5, Para 29
[2] Submission 5, Regular Defence Force Welfare Association, p.2, Paras 6 and 7
[3] Submission 9, Department of Defence, pp.4-5, Para 21
[4] ANAO, *Australian Defence Force Health Services*, 1997,Audit Report 34 of 1996-1997, see Paras 2.16-2.17.
[5] See Submission 5, Regular Defence Force Welfare Association, p.

h) Is it the case that when urine testing for uranium was made available after the Gulf War, it was offered only to personnel still serving[6]?

i) Is it the case, as has been stated, that the ADF cannot guarantee standards of documentation, health surveillance etc if it operates under the command of another country during a deployment[7]?

RESPONSES

2.

a) When ADF health tenders are evaluated, if appropriate providers are not identified, then Defence does not compromise its required standards.

b) At the strategic, operational and tactical levels, headquarters staff includes dedicated health planning staff. There are both single Service and tri-Service courses which teach operational health planning to ensure that, as part of their normal professional development, those who fill health planning appointments have the appropriate skill sets.

Commanders seek advice from those staffs early in the planning process. Frequently the time needed to complete vaccination schedules to protect against a particular threat in an area of operations will have a direct influence on how quickly troops can be deployed fully protected against that threat. The environmental threat assessment, which is prepared by health intelligence staff, has a direct effect on the make up of any deployment as health support is configured, and pre-deployment preparation is tailored, to meet the operational, occupational and environmental threats.

As a general principle, and in line with United Nation's policy, as a Troop Contributing Nation, the ADF provides its own primary health care.

The general policy with respect to post-deployment health care is in Health Directive 222 - *Health requirements for deployed Australian Defence Force Personnel.* This is available on the Defence Intranet and is published on the Internet. For each operation a specific Post-deployment Medical Insert Slip is developed. This document is issued widely in Health Support Plans. It addresses the mission-specific health threats, environmental hazards and prescribed eradication courses to be undertaken. The Medical Insert Slip is placed in the member's medical documents for post-deployment action. Each individual also undergoes a health assessment and a follow-up psychological screen approximately three months post deployment.

c) Yes. It is true that Defence has experienced difficulty in recruiting and retaining sufficient numbers of health professionals in a range of disciplines. This has not been a matter of policy; it reflects the current extremely competitive employment environment. This is currently being addressed through a number of initiatives such as career and remuneration reviews.

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[6] Submission 2, Confidential, p. 3

[7] Submission 5, Regular Defence Force Welfare Association, p.3, Para 12, Para 17

d) The current ADF medical screening processes are heavily focussed on preventive health and lifestyle issues. A working group has recently been formed to review our current health examination processes and determine if a change in emphasis towards a more occupational focus is warranted. This will involve extensive consultation and the development of a business case to support any move away from the current system.

e)

i) No. The standard of health care provided to ADF members is determined by policies aimed at maintaining a fit and healthy deployable force, and are in keeping with usual community expectations of a good health care system. While efforts are made to provide health services cost effectively, standards of care are not sacrificed to achieve cost reductions.

ii) Performance standards in the delivery of health services are expected to meet the appropriate professional standards of good practice. Key performance indicators are in place for ADF personnel and achievement is monitored centrally by the Joint Health Support Agency. Performance indicators are tailored to ensure the maintenance of individual fitness and a fit and healthy deployable force.

f) There are set performance indicators that measure the quality of healthcare against clinical benchmark standards. Clinical benchmark standards are based on a comparison of key performance indicators (KPIs) across Defence health care providers. KPIs used in health support for Defence address quality of care and indicate individual readiness. The KPIs are mostly aligned to civilian standards as determined by the *Report on Health Sector Performance Indicators 2001,* Queensland Health, Brisbane.

g) The ADF is seeking to improve its knowledge and training in the area of occupational health. As a response to the F-111 Board of Inquiry, Defence Health Services Branch has proposed the creation of a centre of excellence in occupational health to provide a critical mass of expert knowledge, advice and training. Improved education, awareness and regular review of workplace practices should reduce unnecessary exposures in the workplace. This proposal is currently being considered by the ADF Occupational Health and Safety project team.

h) Yes. Former members of the ADF who are concerned about possible depleted uranium exposures can approach DVA and, if they have not already done so, can lodge a claim. As part of the investigation of the merits of their claim, DVA can undertake urinary uranium testing.

i) The only two countries under whose command ADF personnel have ever operated, or are likely to operate in the near future, are the UK and the US. Both those countries, along with Australia and Canada, with New Zealand as an observer, are members of the Australia, Britain, Canada and America Standardisation Program. The Program develops Quadripartite Standardisation Agreements (QSTAGs). QSTAG 470 – *Documentation Relative to Medical Evacuation, Treatment and Cause of Death of Patients* sets documentation standards which are agreed by all parties while QSTAG

2042 – *Common Principles for Deployment Health Surveillance* does the same for health surveillance.

3. **Review of Health Services**

Was there a particular reason for the current review of Defence Health Services? Will it take into consideration the role played by DVA and the potential for better combination (see Appendix F to Submission 9, copy attached)?

RESPONSE

3. The purpose of the Defence Health Service (DHS) Review, conducted by Major General J.P. Stevens, AO (Retd), was to evaluate whether the DHS was able to meet Defence's need for health services in the short to medium term and to propose any changes that may be necessary to achieve this.

Whilst the Review focused on the capability of DHS, it also considered the following issues:

- capability requirements of DHS, both operational and garrison support in nature;
- the suitability of existing medical and physical fitness standards as input to ADF readiness;
- the strategies and programs currently in place to deliver health services;
- the DHS workforce - Permanent and Reserve;
- recruiting and retention, workforce 'gaps' and strategies to overcome them;
- the broad suitability of existing training, career structures and remuneration of DHS personnel;
- arrangements for the command, control, leadership, governance and management of DHS, including, in particular, the means to provide health advice at the strategic and operational levels;
- the extent to which elements of DHS could be outsourced, taking into account value for money, support for operations and the maintenance of appropriate ADF health and physical fitness standards;
- 'outreach' to the civilian health community;
- any significant equipment deficiencies; and
- funding required to provide the capability, noting trends in health costs in the civilian community, and Defence strategies to deal with increased costs to Defence.

4. **Standards of care/Duty of care**

a) In cases where it has been clearly demonstrated that inadequate care has been provided, what action is taken by Defence against the individuals who failed to provide a suitable standard of care?

b) If the unsatisfactory service provider has left the ADF, does Defence advise the relevant state authority (eg nurses registration association, medical board)?

c) If failure to provide care or a failure to observe duty of care, is demonstrated, are these adequately addressed by the current compensation scheme?

d) In its 1997 report the ANAO referred to the large number of relatively young people discharged in the early to mid 90s ADF on disability grounds[8]. Has this situation improved at all, and if so what are the main reasons?

RESPONSES

4.

a) If, following investigation, it is found that an individual has failed to provide a suitable standard of care, the action taken by Defence is dependent on the context. If the health provider is military, the matter is dealt with according to the Defence Force Discipline Act – or the accepted recommendations of the investigation. If the health provider is a contract health practitioner, the contract can be terminated if the provider has voided the terms of their contract. If inadequate care has been provided to an ADF member within a civilian setting, the matter can be referred to the Civilian Health Complaints mechanism of the state in which this occurred. At all times, natural justice will prevail, both for the health provider concerned and the complainant.

b) No. Under Administrative Law Defence does not have an obligation to advise the relevant state authority of unsatisfactory service. Advice from The Defence Legal Service was that the relevant state authority should not be advised.

c) The DVA, through the Military Compensation and Rehabilitation Scheme, is responsible for any decision regarding the Commonwealth's liability and any subsequent compensation that may be payable to an ADF member following an adverse event related to a failure to provide appropriate health care. This is available under the provision of 'unintended consequences of medical treatment'.

d) The discharge figures shown in the table below were obtained from the Army Recruit Training Centre (ARTC). There has been a significant reduction in the discharge rate since the mid 1990s. This has been due to the implementation of a number of prevention strategies over that time. The 5 per cent discharge rate in 1998/99 is artificially low because it occurred during the introduction of common Reserve and Regular recruit training. Injured reservists were sent home rather than being discharged and urged to return when better. Subsequent Army Readiness

[8] ANAO, *Australian Defence Force Health Services*, 1997,Audit Report 34 of 1996-1997, Chapter 7 – this was an unfunded liability, though, and not part of the cost of health care

requirements have stopped this. The later rates of 10-13 per cent better reflect the true discharge situation. This represents a greater than 50 per cent reduction in discharges over the last 10 years.

	Total Discharge Rate (%)
1994-95	23
1995-96	17
1996-97	15
1998-99	5
2002-03	13
2003-04 (YTD)	10

The lessons learnt at ARTC have been packaged as the Defence Injury Prevention Program which is in the process of being implemented across the ADF.

5. **Mental health**

a) Is it the belief of the ADF that psychological problems are an almost inevitable outcome of deployments?

b) In your submission, you state that there is a process of psychological briefing[9]. Does the post deployment assessment also cover psychological de-briefing[10]?

c) One submission notes that there may be a lack of psychological screening pre-deployment which can have serious effects later on[11], especially when counselling or debriefing is inadequate. Can you comment on this? Is it valid to say that younger veterans in particular may need more psychological/ psychiatric services[12]?

d) In what ways does the ADF ensure there is adequate follow-up of persons who have been deployed to identify possible mental health problems that may take some time to become apparent? For example, is there interaction between ADF Health and DVA to check if there has been an increase in reports of mental illness or claims for compensation in respect of mental illness?

e) If it can be demonstrated that personnel are affected by problems which they did not have prior to a deployment, is there a barrier to accessing treatment, even though they have to wait for scientific 'proof' before becoming eligible for a pension?

RESPONSES

5.

a) It is assumed that the question relates to operational deployments and not exercises and routine ship deployments. Psychological problems are not 'almost inevitable' but will depend on the perceived stressors of a deployment, and individuals subject to

[9] Submission 9, Department of Defence, p.5, Para 23
[10] Submission 9, Department of Defence, p. 3, Para 11 does not specifically state there is psychological screening on return
[11] Submission 6, Australian Peacekeepers & Peacemakers Association, pp. 2-3, Paras 9-14
[12] Submission 6, Australian Peacekeepers & Peacemakers Association, p. 2, Para 9

those stressors will react differently. For those who are affected, most will find that the psychological symptoms are transient and will result in no long-term adverse outcomes.

b) Yes. The post-deployment support includes education on a range of issues related to integrating back into home and work/life prior to returning to Australia, the completion of a psychological screening test and a screening interview with an ADF mental health worker. The aim of this screening process (formerly called debriefing) is to identify whether there are any symptoms present that might require immediate support for the member.

c) The ADF does not conduct routine pre-deployment screening but does conduct assessments by request. There are a number of significant issues with the application of pre-deployment screening, not least the possibility of disadvantaging an individual who is incorrectly screened out from deployment. Another major issue for pre-deployment screening is that, by the nature of pre-deployment activity, individuals will be experiencing an elevated level of activity and some levels of anxiety that diminish the accuracy of the screening methodology.

We have no data to suggest that younger veterans are in need of more psychological support than any other veterans. Early detection and intervention is the most appropriate response and the ADF Mental Health Strategy uses the public health model of mental health service delivery which has early detection and intervention as one of its cornerstones.

d) Follow-up screening of deployed individuals occurs 3-6 months post deployment and then the same screening instruments are administered every five years as part of the individual's Comprehensive Preventive Health Examination. This way, a comprehensive picture of the mental health of the individual is developed in order to identify, where possible, the early onset of any problems.

The DHS and DVA have very strong links through the Defence/DVA Links Program and the Mental Health Focus Group that is part of this program. There are also very strong links in the research area though joint participation in the Australian Centre for Post-traumatic Mental Health.

e) No, one of the principles for the delivery of mental health in the ADF is that ADF members can have access to treatment and management for any mental health problem irrespective of its cause.

6. **The Mental Health Support Unit**

What is the role of this Unit, and to what extent is it linked to the Australian Centre for Post-Traumatic Mental Health?

RESPONSE

6. There is no unit in the ADF called the 'Mental Health Support Unit'. There are a number of mental health elements in the ADF. The Directorate of Mental Health, which sits within the Defence Health Service Branch, is responsible for implementing

the ADF Mental Health Strategy. It has very close links with the Australian Centre for Post-traumatic Mental Health, with senior staff from both organisations meeting at least quarterly.

7. **Research**

What research areas would you concentrate on if you had untied funding? In your Submission at p.7,[13] you refer to ADF's involvement in research projects that have a very broad application, such as the work on malaria. Is this work done only because funding is available from the United States?

RESPONSE

7.

The ADF documents health and human performance research requirements in a Master Plan, which is reviewed and updated annually. While this document is heavily influenced by the extant capabilities of relevant research organisations in Defence, the plan also indicates areas of research interest for which there is no intrinsic capability. The intention is that the Centre for Military and Veterans' Health will link into external organisations that may provide some of those capabilities and the Master Plan should evolve to reflect more accurately research 'requirements' that could be addressed in these ways. Examples of areas where operationally relevant research might be undertaken are in the areas of gastro-intestinal disease and combat casualty care.

The extant ADF organisations which conduct research in relevant areas have developed capabilities which are in response to specific ADF needs. For example, the Army Malaria Institute is tasked with vector borne disease research, such as research into malaria prevention. These diseases are of particular military significance to the ADF because of our regional interests. While the detail of research programs of organisations such as the Institute might be influenced by opportunistic resource considerations, the programs are responsive to directed ADF requirements.

[13] Submission 9, Department of Defence, p.7 , Para 34