CHAPTER TWO

DEPLOYMENT HEALTH

Deployment and health care planning

2.1 The United States and the United Kingdom have developed new health strategies relating primarily to deployment and to identifying and addressing the problems that occur in conflict.

> The US military underwent substantial changes after the end of the Cold War, resulting in a smaller, more flexible, lighter–equipped and more lethal military force with new health care needs. To meet and adapt to these changes, the Department of Defence developed an innovative health care strategy to protect the health of its soldiers, sailors, airmen and marines. This strategy, called Force Health Protection (FHP), uses preventive health techniques and emerging technologies in environmental surveillance and combat medicine to protect all service members before, during and after deployment. FHP is designed to improve the health of service members, prepare them for deployment, prevent casualties and promptly treat injuries or illnesses that do occur.
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> The overarching goal of FHP is casualty prevention, achieved through a physically and mentally fit force trained for modern combat and supported by mobile, technologically advanced medical teams. FHP has re–engineered the military's approach to combat medicine—expanding beyond acute care services and toward proactive, preventive services that improve the health of service members and identify and address medical threats before casualties can occur. Three interrelated pillars support the goal of FHP:
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> - A Healthy and Fit Force
> - Casualty Prevention
> - Casualty Care and Management.[1]

2.2 The United Kingdom's Defence Health Programme 2003–2007 outlines similar objectives, with an emphasis on linking preventive health strategies to the availability of a competent deployment force:

> From the outset it has been our declared intention to work together with the wider military, the NHS and independent healthcare providers to deliver the required Deployable Medical Operational Capability and a health and

1 United States, Department of Defence Force Health Protection (FHP) at www.ha.osd.mil/forcehealth/about/main.

> healthcare system that maximises the number of Service personnel fit for task.[2]

2.3 The United States in particular has used the considerable research resources of agencies such as the Institute of Medicine (IOM) and other branches of the National Academies of Science to further pre deployment and deployment health plans. The Institute of Medicine has produced several reports on military and veterans' health, and recommended that effective health strategies for deployments required stringent data collection and recording. In its study, *Protecting Those Who Serve: Strategies to Protect the Health of Deployed U.S. Forces* (2000) the Institute identified concerns about the rate of implementation of such recommendations:

> The overwhelming victory that [defence forces] achieved in the Gulf War[3] has been shadowed by subsequent concerns about the long–term health status of those who served. Various constituencies, including a significant number of veterans, speculate that unidentified risk factors led to chronic, medically unexplained illnesses, and these constituencies challenge the depth of the military's commitment to protect the health of deployed troops.
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> Recognising the seriousness of these concerns, the US Department of Defense (DoD) has sought assistance over the past decade from numerous expert panels to examine these issues. Although DoD has generally concurred in the findings of these committees, few concrete changes have been made at the field level. The most important recommendations remain unimplemented, despite the compelling rationale for urgent action. A Presidential Review Directive for the National Science and Technology Council to develop an interagency plan to address health preparedness for future deployments led to a 1998 report titled *A National Obligation.* Like earlier reports, it outlines a comprehensive program that can be used to meet that obligation, but there has been little progress toward implementation of the program.[4]

2.4 The report, *A National Obligation*,[5] identified many of the administrative and planning issues that limited the capacity for immediate follow up of troops from the first Gulf War:

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2 United Kingdom, Defence Health Programme 2003-2007, p. 3 at www.mod.uk/publications/dhp. See also the concordat between the NHS and MoD at www.mod.uk/linked_files/publications/concordats/doh_mod_concordat.

3 The United States uses the term 'Gulf War' to cover both the 1990–91 war and the conflict in Iraq, distinguishing between these by the names of operations. This has facilitated access by veterans to various services set up after the first Gulf War as much of the administration work involved in determining conflict linked injury and disease has already been done.

4 See www.nap.edu.books/0309071895, Executive Summary, p. 1.

5 United States, National Science and Technology Council, *A National Obligation, Planning for Health Preparedness for and Readjustment of the Military, Veterans, and Their Families after Future Deployments* (1998), response to Presidential Directive No. 5 at www.ostp.gov.NSTC/html/directive5.

> Federal agencies discovered numerous health related deficiencies in monitoring the health of deployed troops. For example, our record keeping capabilities were not designed to track troop and asset movements to the degree needed to determine who might have been exposed to any given environmental or wartime health hazard. Seven years later, we just now have a complete accounting of who was actually deployed to the Gulf.
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> In addition, we discovered major deficiencies in the way we approach health risk communication. While the desire is strong to disseminate all relevant health information to the affected groups as soon as possible, we must ensure that information is delivered in a way that is understandable and causes neither unwarranted concern nor undue complacency. We must ensure that even during wartime situations, the military leadership ensures accurate communication of risks associated with countermeasures, such as vaccines, and maintenance of accurate records.[6]

2.5 While noting that the number of persons killed and injured in war was small, the report concluded that unknown or unexplained illnesses or symptoms, and accidental injury were some of the later consequences which had not been foreseen and therefore not provided for.

> However, DoD and VA were not fully prepared to recognise, respond promptly, and treat the type of health problems reported by a large number of Gulf War veterans. The number of veterans wounded or injured in the line of duty was small, but new challenges included:
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> - the possibility of injury due to chemical and biological warfare agents;
> - concerns over chronic diseases due to infectious and toxic exposures;
> - unexplained post–deployment symptoms;
> - concerns over illnesses with long latency periods following exposure;
> - concerns over illnesses that might affect family members, close contacts and children conceived post–deployment; and
> - higher rates of motor vehicle injury and death, and of other accidental injury, among war veterans. [7]

2.6 These comments suggest that attention must be paid not only to injury that occurs during conflict, but also to the longer term effects of it. This may appear contradictory, given that some of the difficulties experienced by past veterans have been the lack of immediate services,[8] but it indicates more that some of the longer term outcomes do not always appear obvious, however much they may be connected to conflicts.

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6 See www.ostp.gov.NSTC/html/directive 5.

7 www.ostp.gov.NSTC/html/directive 5.

8 See Chapter 4, paragraphs 4.3, 4.34–4.44.

ADF health service outsourcing

2.7 ADF Health services have been subject to considerable review in recent years,[9] with recommendations generally suggesting greater centralisation and more effective utilisation of resources, an emphasis on appropriate levels of staffing, and an awareness of good health as a necessary part of an effective deployable force.[10] This has led to more outsourcing of medical services, although this also reflects the employment market.

> 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.[11]

2.8 Some submissions suggested that with the reduction of qualified staff within the ADF, there had been a reduction in corporate knowledge. This was linked to the outsourcing of some services:

> I think that, if you are outsourcing, the pool of people that you have in the uniformed health service that have day–to–day knowledge of some of the conditions that service people come across, particularly from some exotic environmental threats, is diminished …you do not gain the corporate knowledge. And this was perhaps the experience at Amberley, with the conditions experienced there. [12]

2.9 However, outsourcing of service provision is not in itself a problem, and may be a more efficient way of meeting peaks and troughs in demand. It could create some problems if it were seen that some services were not available, but service provision is already limited to some degree to what is seen as necessary, not what is available.[13]

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9 See Brigadier Paul Buckley, 'The Defence Health Service—formative steps', *ADF Health*, 1 (November 1999), p. 8.

10 Budget estimates, FADT, 4 June 2003, p. 363. *Submission 9*, Defence Organisation, p. 1, paragraph 3.

11 *Submission* 9B, Defence Organisation, p. 4, Q2 (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'.

12 *Committee Hansard*, p. 8. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29: 'Knowledge of the unique environmental exposures associated with ADF service and deployments is not as widespread within the ADF health system as it should be or used to be and this is compounded by the increasing outsourcing of Defence health services to a civilian health population that has had no experience of Defence service.'

13 In addition, some specialist services may not be approved as either not necessary for deployment/operational purposes or as making personnel unfit for these purposes: see DJHSA Directive 07/03, 30 July 2003, *Non Standard Health Care Procedures in the ADF,* p. 1: 'It

There could also be a belief that there is a rationing of a particular level of service, and that those who do not have access to it are less valued. However, Defence emphasised that cost was a secondary factor.

> 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.[14]

2.10 Although Defence witnesses conceded there had been a reduction in service providers with knowledge and experience in the type of diseases and injuries, and also of the environmental hazards likely to be experienced by personnel, they stated that this was only likely to be the case in areas where there was little deployment. Appropriate staff, that is those who were within the ADF, were available for personnel on deployments or who had been on deployments previously.[15] Nonetheless, it is obvious that efforts were also made to ensure that the contracted health practitioners became aware of the nature of ADF work[16] and kept up with relevant courses.[17]

2.11 Another issue raised in evidence was that outsourcing could signify a loss of expertise within the forces which could have long term effects in several ways,[18] such as a loss of status through being dependent on other departments for information:

> Early last year, when the second Gulf War deployments commenced, there were statements in service newspapers by the Commonwealth Chief Medical Officer to support views about anthrax vaccinations. To me, that jarred a bit. I thought you would seek the advice of a person like that about an outbreak of meningococcal infection in a base camp, but when you are talking about weaponised systems involving chemical or biological agents that core expertise should be in Defence and recognised as such. That is an

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should also be noted that, should it be undertaken at the member's cost,—the outcome may not be compatible with the maintenance of a deployable profile IAW references A and B.'

14 *Submission* 9B, Defence Organisation, p. 4, Q2(e).

15 *Committee Hansard,* p. 72 and see above, paragraphs 2.7, 2.9.

16 Some familiarity with the work of ADF personnel was to be obtained through all CHPs being given 'the opportunity to attend at least one field day annually with a major unit from the establishment in their normal working and training area,' DJHSA Directive 10/04, 7 April 2004, *Orientation of Contract Health Practitioners Working on Australian Defence Force Bases,* p. 2.

17 'Area Health Services may fund attendance of contract health practitioners on selected ADF health courses, and on those professional body health conferences which have a military component…', DJHSA Directive 10/02, 17 September 2002, *Contract Health Practitioner Attendance at ADF Medical Courses*.

18 See *Submission* 5, Regular Defence Force Welfare Association Inc, p. 5, paragraph 29.

> example of what, to us, appears to be a run-down. Whether or not that run–down is substantiated, I do not know; it is just an example.[19]

2.12 While there is some truth in this, it is likely that a greater danger to personnel is not loss of status, but whether the expertise of qualified scientists and medical practitioners is available and properly utilised and whether the overriding culture is one which values health and safety at all times.[20] Where a department is outsourcing, or seeking expert input, it is sensible to use the expertise of specialist agencies, and in effect the ADF does this through closely following key documents such as the Australian Immunisation Handbook. [21]

2.13 Given the substantial experience of the US and the UK in biological and chemical warfare issues, much of the information available on various hazards, exposures and material that is used, comes from research undertaken there. The only 'Australian input' required is approval of the information and of any substances such as vaccines. The capacity to deal efficiently with queries about anthrax and other hazards, including environmental exposures such as *du*, does not invariably require that high level medically or scientifically qualified persons be within the armed forces. It may be reassuring to have a member of the ADF announce a particular 'medical' program, but in reality this is unlikely to have proceeded without some input from qualified external agencies, including those from overseas.

2.14 However, the suggestion in one submission that there was a clear link between guidelines on issues such as informed consent and the availability of 'highly qualified medical officers to advise the command in this area,'[22] does raise some questions about the extent to which medical staff are involved in decision-making at the higher levels. The discussion on the anthrax immunisation issue indicates that there were problems with access to informative material for medical staff on the *Kanimbla*, the timely availability of which might have limited the concerns of personnel.[23]

2.15 However, a greater problem is likely to be whether the advice available at the planning stages of deployments identifies medical and other issues such as not giving anthrax vaccinations at the same time as others, or the practical effects of not agreeing to receive a particular vaccination.[24] In the particular instance of the anthrax vaccinations, the combination of poor quality and sometimes contradictory

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19 *Committee Hansard*, p.8. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraphs 8–10.

20 See *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraph 4.

21 See especially Appendix 3, below, and also *Submission* 9, Defence Organisation, Appendix D, ADFP 1.2.2.1 paragraph 1.10.

22 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 4, paragraph 25.

23 See Appendix 3.

24 See Appendix 3.

information and incomplete medical data resulted in an unnecessarily chaotic situation. While the ADF has accepted that providing information earlier would have been better, it also needs to ensure that its management obtains clearer information itself.[25]

2.16 Defence advised that generally:

> 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.[26]

2.17 Many of the programs recently developed demonstrate that the ADF has moved increasingly towards the approach set out by the US and the UK, a move which will be supported by the development of the Centre for Military and Veterans' Health. Following the reviews of Defence health services, specific objectives were outlined as a part of the Defence Reform Program:

- Provide a fit and healthy force which contributes to ADF mission success;
- minimise preventable injury and illness;
- provide appropriate and timely treatment;
- develop the capability of the Defence Health Service to support ADF requirements; and
- Provide a well managed adaptive and adequately resourced quality health system.[27]

2.18 Overall, the Defence submission to this inquiry did not consider that there were problems in providing adequate services as part of an holistic approach -'routine health care prior to deployment includes the monitoring of health and fitness standards',[28] and emphasis was placed on members of the ADF having responsibility for their own readiness for deployment.[29]

2.19 At the same time, the ADF emphasises that, given rationalisation of resources, the allocation of uniformed medical personnel will be to the areas likely to be

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25 See Appendix 3

26 *Submission* 9B, Defence Organisation, p. 3, Q 2(b).

27 See Brigadier Paul Buckley, 'The Defence Health Service—formative steps', *ADF Health*, 1 (November 1999), pp. 5–6.

28 Budget estimates, FADT, 4 June 2003, p.363. *Submission* 9, Defence Organisation, p. 1, paragraph 3.

29 *Submission* 9, Defence Organisation, p. 2, paragraph 9 and p.4, paragraph 21.

deployed, and the provision of health care is geared directly to operational requirements.

> Health care delivery in the Australian Defence Organisation is made up of four components: the active duty men and women of the ADF, the Reserve component, an element of Australian Public Service people, and a pool of contractors. The ratio of those four elements will depend on the base that you are looking at. If you go to an operationally focused base then the preponderance of providers will be uniformed people. It has been the thrust of the reorganisation of Defence Health Services to concentrate a scarce resource—that is, uniformed health providers—to our operational bases.[30]

2.20 The reason for this allocation is presumably that medical personnel within the ADF are seen as having a greater understanding of the needs of the ADF, and are more likely to have military–specific expertise. Where this experience is recent, this may well be true. However, unless there is detailed information available on day to day activities of individuals, many medical professionals may not be aware of some of the factors affecting their patients' health—otherwise many problems would have been identified long ago. It should also be borne in mind that, just as there may be problems with psychologists being used to try to get people to change their minds,[31] there is also a need for doctors and nurses to remember that their main duty is to the patient and not to the ADF. No detailed instances were given to this inquiry of any case in which there was a conflict of roles, but the use of civilian medical staff may provide a balance.

2.21 The provision of health care, while linked to Medicare, is directed primarily at maintaining a high level of fitness for operational duty:

> …equity with Medicare underpins the basic entitlement to the range of medical services available. The provision of health care differs to that available to the general public in that the range of, and ease of access to health care provided to the ADF will exceed that available through the public health care system because of the requirement to meet and maintain operational readiness. Conversely, the Director–General Defence Health Service (DGDHS) may also issue policy which precludes or limits the provision of certain medical and dental treatment, despite its availability on Medicare, on the grounds that it is either contra–indicated or unnecessary for operational readiness.[32]

30 *Committee Hansard,* p. 72.

31 See Redress of Grievance, Attachment to *Submission* 10, Mrs Screaton, paragraph 34, see also Appendix 3.

32 Joint Health Support Agency, DJHSA Directive 07/03, 30 July 2003, *Non Standard Health Care Procedures in the ADF.*

Health Services

Pre deployment

2.22 Planning for overseas deployments includes the assessment of health threats and the development of health support plans which operate across the pre deployment, actual deployment and post deployment stages.[33] The rate at which such strategies are developed may vary:

> The task of conducting health [threat] assessments is research and analysis based, requiring the coordination of a large amount of corporate knowledge to gather information and formulate coherent policy before it is turned into strategic guidance.[34]

2.23 There is an ongoing requirement for the collection and analysis of data which will help establish an information base about the deployment area, including endemic diseases, water and electricity supplies, and availability of established health services. While it is to be expected that many details of a deployment area may need to be revised, there seems to be little reason why a substantial amount of the information which is regularly collected would not have been analysed and a 'coherent policy' able to be put in place rapidly. More information on the day to day role of staff involved in the collection and analysis of information may indicate a need for a more efficient approach which could limit the time required to provide a basic strategy when decisions are made for deployment.[35]

2.24 This is especially important given that the existing health and environmental threats may determine personnel to be deployed (those already fully vaccinated) more than the deployment waiting on personnel to be available.

> Commanders seek advice from [health planning] 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.[36]

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33 *Submission* 9, Defence Organisation, p. 1, paragraphs 2–4, p. 2, paragraphs 6–9, pp. 2–3, paragraphs 10–13.

34 *Submission* 9, Defence Organisation, p. 3, paragraph 12.

35 *Submission* 9, Defence Organisation, p. 3, paragraph 12.

36 *Submission* 9A, Defence Organisation, p. 3, Q2(b).

Data collection/analysis and information

2.25 The 'health threat assessment' is developed by two agencies, the Defence Health Service Branch (DHSB) and the HQAST.[37] Without such plans, a deployment is likely to encounter substantial problems which will affect its capacity to undertake the deployment effectively. No problems were identified by Defence in its statements about current arrangements, but some submissions and oral evidence indicated flaws which may have arisen from these plans or from an inability to provide services as required by plans. One example was the lack of adequate protection from malaria experienced by personnel in East Timor.[38] Another referred to lack of information about environmental hazards:

> …recent discussions by Federation staff with East Timor veterans identified that many of them were unaware of many of the chemicals and substances which were known by Defence to be present in the area of operations. Although it is accepted that many of these hazards did not become apparent until personnel were in-country, subsequent briefings and information have not been forthcoming or adequately recorded for future reference.[39]

2.26 It is not clear what detail is provided to personnel on health threats, and to what extent they are required to keep themselves up to date, and seek additional information in the field, although some updates are provided:

> …once they are deployed there is an ongoing education program, which is usually conducted by the health providers, and that is either of a generic nature in relation to the operation itself or it may be focused, depending on things that have happened locally, such as an outbreak of gastroenteritis or that sort of thing.[40]

2.27 Nor is it clear if all personnel are able to accurately assess their exposures or risk of exposure to disease and environmental hazards.[41] Information about certain aspects of health plans are confidential, and personnel will only be allowed to know what is deemed necessary.[42] Even if they are aware of all relevant issues, inadequate provision of required medication or other services will limit the usefulness of this knowledge. Lack of effective monitoring of individuals, to ensure that they have not exceeded dosage of particular drugs, also appears to be lacking.

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37 *Submission* 9, Defence Organisation, p. 2, paragraphs 6–7.

38 *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2, paragraphs 4, 5.

39 *Submission* 3, Armed Forces Federation of Australia, p. 1.

40 *Committee Hansard,* p. 89.

41 *Submission* 9, Defence Organisation, p. 1, paragraph 8. See also chapter 3.The US in particular has collected some exposure data, but this may have limited value unless it can be matched to individuals through HealthKEYS, see below, paragraphs 2.64–2.66.

42 See Appendix 3.

> We are not 100 per cent sure of, and have not been provided with, the long-term effects of taking doxycycline for, say, seven to eight months. One particular case comes to mind of a member who did a number of deployments in a row and ended up being on doxycycline for some 13 or 14 months.[43]

2.28 Defence stated that information is provided on drugs used in deployments, including doxycycline,[44] but because doxycycline was common, not much information was given to personnel.[45] There was no mention of any studies on long term effects, although concern was expressed about the status of individuals for G6PD, 'a particular enzyme we are worried about in relation to antimalarials'.[46]

2.29 It is possible that a 'need to know' policy also limits both collection of information and its distribution:

> …the quality of early advice may be affected by the inability to consult with some supporting agencies.[47]

2.30 However, Defence considers that the information it provides pre-deployment is detailed, and includes data on 'potential operation, environmental and occupational hazards that may be encountered'. It is also the case that different forces may have different health needs, because the nature of their work may vary considerably.

> When the ADF engages in an operation, operational health threat countermeasures are not always universal across the three services because they may be operating in different operational milieus. Historically, Navy personnel have not received the suites of protective agents that, for instance,

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43 *Committee Hansard,* p. 30, Australian Peacekeepers & Peacemakers Association.

44 *Committee Hansard*, pp. 88–89.

45 *Committee Hansard*, p. 8: 'doxycycline is a registered drug in Australia and it is widely used, so we do not spend a lot of time telling people about it, nor do we require a signed consent from them'.

46 *Committee Hansard*, p. 76. Doxycycline is an antibiotic (tetracycline) which is used for several health problems, including as an anti-malarial and anti–anthrax drug. It is used as an anti-malarial in areas which have become mefloquine resistant (Mefloquine is an older anti-malarial which no loner provides adequate coverage against malaria in some areas) and this includes the Pacific region. It does have side effects including gastrointestinal upset and esophagitis. It can also be photo sensitizing, and therefore adequate sunscreen protection is required. It is contraindicated in pregnant women, Stephen J. Gluckman, 'Prevention of malaria in travellers', *American Family Physician*, 1 August 2003, pp. 3–4, www.findarticles.com/doxycycline). Although one source indicated that long term use of tetracyclines was tolerated well, another stated that some sources do not recommend taking it for more than three months (Australian College of Tropical Medicine, Faculty of Travel Medicine, *Travel Medicine Briefcase*, 2 (December 2001) p. 1). The Australian College of Tropical Medicine refers to the fact that there are no long-term anti–malarials, and mentions doxycycline as a short term drug. If this information was available, it does not appear to have been transmitted to the individual who had been taking it for 14 months.

47 *Submission* 9, Defence Organisation, p.3, paragraph 13.

> ground forces may receive because the nature of their duties is quite different and their risk of exposure is different. So, whilst a decision may be made for ground forces to be protected against anthrax based on threat assessment, the issue of whether Navy personnel should receive similar protection is not always clear cut. A lot of that will get down to quite pragmatic issues of where the ships will operate, the ports they will use, the probability of their personnel going ashore—there is a whole range of issues that need to be consulted.[48]

2.31 Examples of this variation were seen in the first Gulf War, with the majority of forces being naval, and consequently limited vaccination being required.[49]

Mental health

2.32 A psychological briefing is also given, 'emphasising operational stress training' [50] and a pamphlet containing 'practical information relevant to the Area of Operations with effective disease minimisation and prevention advice as well as mental health information' is issued.

> 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.[51]

2.33 Nonetheless, it is possible that some personnel already emotionally adversely affected by previous deployments, or those especially vulnerable, may neither be picked up through the assessment process nor assisted by this information. One submission noted that there may be a lack of psychological screening pre deployment which could have serious effects later.[52] That there was in fact little early psychological assessment was noted in other material:

> At this stage we are not doing a comprehensive mental health assessment of people at recruitment….
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> It is the goal of the mental health team to develop comprehensive recruitment profiling which can then form the baseline for further assessments.[53]

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48 *Committee Hansard*, p. 64. See also *Submission* 9B, Defence Organisation, p. 1, Q1(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'.

49 *Committee Hansard*, p. 61.

50 *Submission* 9, Defence Organisation, p.5, paragraph 23.

51 *Submission* 9B, Defence Organisation, p. 1, Q1(a).

52 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp. 2–3, paragraphs 9–14.

53 Budget supplementary estimates, FADT, 5 November 2003, p. 104.

2.34 While the development of the mental health teams is an important one, it is likely that early identification of alcohol and substance abuse and of psychological factors (including those contributing to harassment, intimidation etc) would be highly beneficial, preferably at recruitment.[54] There seems little point in providing extensive military training for a person who may be quite unsuited for deployment.

> Psychological assessment at intake cannot identify those more prone to break down in combat, although it can filter out the dull, the illiterate and the severely disturbed—such as those with schizophrenia. Normal men and women can break down.[55]

2.35 However, this is to be distinguished from pre-deployment screening. Defence's reasons for not conducting pre–deployment psychological screening included:

> 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.[56]

2.36 Another reason is that, depending on the length of the campaign, many individuals will be subject to stress, and this cannot be predicted:

> Overall, it was the Second World War that showed that it was not the case that breakdown could be avoided with selection, training and moral fibre, as had been concluded at the end of the First World War. The reality of industrialised warfare was inescapable—eventually, as US statistical inquiries showed—men would breakdown irrespective of training and courage. After about 120 days of combat, most units became incapable of further performance because of psychiatric injuries, which were also proportional to the number of physical casualties.[57]

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54 See *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 36: 'There is psychological suitability testing, psychometric testing, that is completed prior to entry into the service to identify people who are suitable and not suitable. The repeat of that as a tool before deployment may be an idea; I am not too sure'.

55 See John Ellard, 'Principles of Military Psychology', *ADF Health*, 1, 2000, p.83.

56 *Submission* 9B, Defence Organisation, p. 8, Q5(h).

57 *Improving the Delivery of Cross Departmental Support and Services for Veterans—A Joint Report of the Department of War Studies and the Institute of Psychiatry*, Kings College London, July 2003, p. 45, paragraph 5.3.1.3, at

http://news.mod.uk/news_press_notice.asp?newsItem_id=2616.

2.37 The policy with respect to pre–deployment psychological screening was criticised by one submission which suggested the process was inadequate, as was the post deployment screening. The main reason for this was that there were specific differences in mental health issues depending on the nature of deployment, and these were not considered:

> Neither Defence nor DVA have a clear picture of the state of the mental health of young veterans. Furthermore, they have not conducted sufficient research to understand the specific differences in the mental health problems associated with War Like Service and peacekeeping opposed to Peace Making operations. There is a clear requirement for Defence's Centre for Military and Veterans' Health to undertake extensive research into the symptoms and signs of operational stress related injuries for each type of stress injury to ensure the development of better rehabilitation and compensation programs.[58]

2.38 A further relevant factor in problems of identifying mental health is the stigma associated with mental health issues, which Defence has sought to overcome:

> Defence has made significant efforts in a number of different campaigns in order to address those but, at the base level, there is still that cultural problem.[59]

2.39 Defence noted, however, that as part of the information obtained from the study of the first Gulf War, psychological and substance abuse problems were addressed in the planning stages of a deployment,[60] as a means of trying to deal with issues before rather than afterwards:

> …prior to deployment, the members are given a deployment guide, which is quite a comprehensive document that goes into all of the possible problems they may experience prior to deployment, during deployment and on return to their families….The aim of that document is to heighten the awareness of the families about what signs may be significant. Through the Defence Community Organisation they can certainly access social workers and, through them, the regional mental health support teams if the family is concerned about any aspect of the behaviour of the partner who has returned from the deployment.[61]

2.40 In due course, it is assumed that the process that occurred prior to the return of personnel from Iraq will be in place for all deployments—that is, that there is some

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58 *Submission* 6, Australian Peacekeepers & Peacemakers Association, pp. 2–3, paragraph 11.

59 *Committee Hansard*, p. 33, Australian Peacekeepers & Peacemakers Association, and see also below, paragraph 2.89, and Chapter 4, paragraph 4.64.

60 Budget estimates, FADT, 4 June 2003, p. 367.

61 Budget estimates, FADT, 4 June 2003, p. 361.

attempt to identify potentially traumatising events prior to individuals returning home.[62]

2.41 Nonetheless, the responsibility placed on unqualified family members to identify problems appears excessive. The value of regional mental health support teams may be undermined by the lack of professional input in identification of issues at an early stage.

Other preparation

2.42 The health support plan outlines the processes by which adequate health services will be provided to personnel during the whole phase, including pre and post deployment.[63] This includes undertaking health reviews of returned deployed staff, and helping to identify any health issues that may arise in the short or longer term from such deployments. Post–deployment information gathered from various sources including medical reviews can help to determine patterns of injuries and disease arising from conflicts and therefore has a role in the prevention or moderation of such effects in future similar deployments.[64] Updates on the basic plan are provided throughout operations,[65]although these appear to be available to health staff only. This again raises the issue of the extent to which any relevant new information is passed on to those more directly involved, and how it is transmitted.

2.43 As a consequence of the 'readiness for deployment' approach, the ADF considered that it was capable of responding rapidly. All three forces were subject to an annual health review, regardless of need for deployment. When deployment was determined, Army and RAAF personnel underwent an 'update' interview 'to determine if any injury or condition has occurred since their Annual Health Assessment'.[66] While this interview was undertaken by health 'staff', it had to be signed off by a 'medical officer', a term which appears to mean 'doctor'.[67] The effectiveness and thoroughness of this approach will obviously depend both on the qualifications and skills of the health staff and the awareness of the individual, who may have some health problem which has minimal symptoms, or has not been clearly identified.[68] Naval personnel have a 'seagoing medical',[69] although they are presumably also required to remain deployment–ready.

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62 See below, paragraphs 2.69–2.71.

63 *Submission* 9, Defence Organisation, p. 1, paragraphs 4, p. 2, paragraph 10.

64 *Submission* 9, Defence Organisation, p. 4, paragraph 17.

65 *Submission* 9, Defence Organisation, p. 3, paragraph 13.

66 *Submission* 9, Defence Organisation, pp. 4–5, paragraph 21.

67 *Submission* 9, Defence Organisation, p. 5, paragraph 21; see also p. 3, paragraph 11**,** which notes that the medical and dental examinations are conducted by JHSA staff.

68 At the time of writing its submission (January 2004) the ADF had not yet incorporated into the annual assessment any information relating to compensation claims or acceptance of claims, which left the responsibility of identifying any problems to individual personnel. This was a

2.44 Pre–deployment readiness programs are unlikely to include standard inoculations which are part of the 'readiness for deployment' strategy,[70] and will rather comprise those required by the specific environment or situation of the deployment.[71] It is in this area that many of the issues concerning improved standards arose, with out of date vaccines, poor quality information, and apparent unwillingness to accept the effect of symptoms[72] all seen as evidence of second rate services. Another submission stated that given the extensive literature available on possible effects of exposures and of vaccinations,[73] an improved process regarding information provision and informed consent was seen as necessary.[74]

Deployment

2.45 There was little information provided on the capacity of the health services during deployments, whether this had been assessed against performance indicators and the extent to which involvement in joint operations resulted in ADF personnel receiving a lesser level of care than they might have expected. Australia provides its own primary level care on deployment, and believes that the standard of other care is appropriate.

> 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.[75]

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matter which the ADF expected to rectify (*Submission* 9, Defence Organisation, p. 5, paragraph 21), although some cross–checking of responses with compensation claims may be necessary in order to determine the exact nature of such claims or conditions for which the individual is being compensated (because the proposed incorporation of this issue into the annual assessment takes the form only of an 'indication' (p. 5, paragraph 21) that may not elicit sufficient detail)—see *Submission* 9, Defence Organisation, p. 5, paragraph 29.

69 *Submission* 9, Defence Organisation, p. 5, paragraph 21.

70 See *Submission* 9, Defence Organisation, p. 2, paragraph 9. These standard inoculations were ADT (adult diphtheria and tetanus; measles, mumps, rubella; polio; hepatitis A and B; and typhoid (Estimates, FADT, 4 June 2003, p. 365).

71 *Submission* 9, Defence Organisation, p. 5, paragraph 22.

72 *Submission* 7, Major Laboo, p. 3.

73 *Submission* 5, Regular Defence Force Welfare Association Inc., p. 4, paragraphs 20–21.

74 See Appendix 3.

75 *Submission* 9B, Defence Organisation, p. 4, Q2(i).

2.46 Material from a 2000 review of the health status of the ADF identified a range of disorders from other deployments but no serious injuries.

> Data from some recent deployments, including Bougainville and East Timor, indicated that almost half of medical attendances were due to skin diseases, injuries, intestinal infections and other infections including dengue fever and malaria. Measures have already been put in place to apply lessons learned to current and future operations.[76]

2.47 As far as the Iraq deployment was concerned, there were no physical injuries of a serious nature.[77] To General Cosgrove, it appeared that in respect of the 2nd Gulf War a similar result emanated from the period of time that was spent acclimatising in the combat zone prior to conflict:

> I believe that the opportunity to acclimatise, to learn of the operating environment and to assimilate or integrate with coalition partners, was a major factor in our people being able to show a professional performance without friction, misunderstanding or those individual factors that exhausted and disoriented service men and women can experience if they are pitchforked into a harsh, hazardous environment at short notice.[78]

2.48 The available statistics on medical discharge do not demonstrate if some claims might have arisen subsequently, or if there were longer term injuries, including mental health problems that might not be obvious or identified until later.[79] Primary health care in recent deployments has been provided by Australia[80]with in patient services being a UN or Coalition responsibility.

2.49 The only issues identified for the deployment period were that Australian forces may have been required to meet standards of another force, and that medical records in deployment areas may not be easily obtained[81] because a hospital was

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76 Department of Defence, Media Release, 'First ADF health status report supports white paper aims', 2000.

77 Budget estimates, FADT, 4 June 2003, p. 358, Senator Evans: 'There seem to have been reports of nothing more than cuts and abrasions which seem quite remarkable given the large number of people and the potential for industrial accidents let alone anything involving a conflict'.

78 Budget estimates, FADT, 4 June 2003, p. 383.

79 Additional estimates, FADT, 18 February 2004, *Answers to Questions on Notice*, Defence, part 2, p. 68.

80 *Submission* 9B, Defence Organisation, p. 3, Q2(b): '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'.

81 United Nations, Office of Mission Support, Department of Peacekeeping Operations, Medical Guidelines for Peacekeeping Operations, Medical Support Unit/ OSD/LMS Hospital Level Medical Care (2003) outlines the standards of equipment and staff to be provided. See www.un.org/Depts/dpko/medical/pdfs/472 hospital care.

under the command of another organisation such as the UN.[82] These issues, especially the latter, can have substantial consequences for people making claims for injury, but the Repatriation Commission believes that many former difficulties are being overcome by different means of obtaining information.[83]

Post deployment

Screening

2.50 According to Defence:

> 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.[84]

2.51 Evidence from earlier Estimates hearings stated that a form of health assessment was given prior to return from deployment,[85] but later information—in respect of the return of troops from Iraq—corrected this to advise that troops had rather been provided with a health briefing prior to return[86] which:

- identified exposures;
- provided pharmaceuticals that might be required; and

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82 In Timor, the original UN hospital at Comoro was established by Australia in 1999 and closed at the end of August 2002. It was replaced by the UN hospital in Dili. Medical staff for the hospital were provided by Australia, Egypt and Singapore. (See www.un.org/peace/timor 040902). However, under the system set up by the UN, hospital care is the responsibility of the UN (United Nations, Office of Mission Support, Department of Peacekeeping Operations, Medical Guidelines for Peacekeeping Operations, Medical Support Unit/ OSD/LMS Hospital Level Medical Care (2003), Introduction, p. 6) even though the facility in which the care is provided and the staff who provide it, may be contracted. This may account for the UN retaining medical records.

83 See Chapter 3, paragraphs 3.39–3.40.

84 *Submission* 9B, Defence Organisation, p. 3, Q2(b).

85 Budget estimates, 4 June 2003, p. 359.

86 See *Correction of evidence…concerning medical examinations for ADF personnel returning from active duty in the Middle East*, Material provided following Budget estimates of June 4, 2003 at www.aph.gov.au/committees/Senate/Foreign Affairs, Defence and Trade, Budget estimates 2003–2004.

- provided information on the post deployment health check.[87]

2.52 Personnel were able to raise concerns with a doctor if they had any further queries. While the process may have improved considerably since this time, a general briefing—even one which raises an opportunity for further private discussion—does not help to identify all issues that individuals may have, since many people may not wish to discuss these. It is not clear from this information what medicines were dispensed and whether these were handed out with adequate information, or took the needs of individuals into account. Defence notes that personnel are issued with cards 'detailing diseases endemic in the Area of Operations',[88] which are presumably linked to the inserts referred to above and which will be used during later medical assessments.

2.53 According to Defence, there is a extensive health screening process in place on return from deployment, although this does not occur for three months:[89]

> After returning from deployment, individuals are subjected to comprehensive health–screening processes. These are designed to eradicate disease and to document and treat potential exposure to operational, occupational and environmental hazards during deployment. These processes include medical testing, psychological debriefing and ongoing health care.[90]

2.54 Although this assessment is an Annual Health Assessment,[91] a three–month gap is surprising, given that numerous health issues may have arisen and need to be tested for. One reason given for this three month period was that 'certain infectious diseases may not in fact manifest themselves on the testing until a period of at least six weeks after return' and that other symptoms or signs might emerge during that time.[92]

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87 See *Correction of evidence…concerning medical examinations for ADF personnel returning from active duty in the Middle East*, Material provided following Budget estimates of June 4, 2003 at www.aph.gov.au/committees/Senate/Foreign Affairs, Defence and Trade, Budget estimates 2003–2004.

88 *Submission 9*, Defence Organisation, p. 5, paragraph 24. This card is apparently meant as a prompt for personnel during the post-deployment period, presumably by listing issues they may wish to raise with medical staff.

89 'All personnel are medically examined three months after returning to Australia and provided with appropriate treatment if required'(Budget estimates, FADT, 4 June 2003, p. 359).

90 *Submission 9,* Defence Organisation, p. 1, paragraph 3.

91 Defence Health Service, Health Directive 222, *Health requirements for deployed Australian Defence Force Personnel*, p.3 paragraph 20, at www.defence.gov.au/dpe/dhs/infocentre/publications/directives/HD222.

92 Budget estimates, FADT, 4 June 2003, p. 360.

2.55 However, this presupposes that various diseases were all caught just prior to return. Given that the average period of deployment in Iraq was 6 months,[93] it is more likely that at least a percentage of personnel would have been infected during the deployment. Diseases, including malaria,[94] HIV,[95] and TB,[96]can provide evidence of infection in short time span and treatment should start then.[97] TB is prevalent in Timor, Iraq and Afghanistan, with the latter two having rates of infection of approximately 142 and 148.9 (1991) per 100,000 respectively[98] which is likely to have increased because of the effects of war,[99] although ADF personnel may be less prone to the disease because of higher levels of overall health, and the relatively short period of time spent in affected areas.[100]

2.56 Personnel are provided with prophylaxis against malaria (found in Iraq, Afghanistan and Timor as well as other regions of the Pacific). This will not necessarily guarantee protection, unless taken as prescribed. One of the disadvantages of doxycycline was considered to be that, as it had to be taken daily, adherence to guidelines might wane.[101] Another problem, as indicated above, is that it may have adverse effects and its long term use should be monitored.

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93 See Budget supplementary estimates, FADT, 5 November 2003, p. 30.

94 See *History of Plasmodium Paragraph sites*, www. wehi.edu.au MalDB.

95 However, prevalence rates of HIV/AIDS are very low in Afghanistan and Iraq—see World Health Organisation (WHO), *Epidemiological fact sheets in HIV/AIDS and sexually transmitted infection*, 2000 at www.who.int/emc_hiv/fact_sheets 2000.

96 'The initial infection with *M. tuberculosis* often goes unnoticed; 95% of those infected enter a latent phase from which there is a lifelong risk of reactivation. The other 5% progress directly to pulmonary tuberculosis or by lymphohaematogenous dissemination of TB bacilli to miliary, meningeal or other extrapulmonary involvement. Infants, young children, older people and the immunocompromised are more likely to progress rapidly to severe generalized infection with poorer outcome. It is common for the initial infection to result in a characteristic nodular lesion in the middle or lower lungs, and this lesion acts as the source of disease during reactivation.' Asia Pacific Vaccination Council, *Tuberculosis: General Information on the Disease and the Vaccine*, www.vaccinenews.net/default.asp? articleID=209&Topic_ID+65.

97 National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition Canberra 2003, Part 2, p. 81: 'The incubation period for inhalational anthrax is thought to range from 1 to 43 days after exposure. The initial phase consists of flu–like symptoms such as sore throat, mild fever, chest pain, cough and myalgia. Within 2 to 3 days, a second phase begins with the abrupt onset of high fever, dyspnoea and hypoxia, rapidly progressing to shock and death within 24 to 36 hours.'

98 www.nevdgp.org.au/genin f/lung_f/tuberculosis.

99 People with poor health status, and limited access to food and medicine, are more vulnerable to TB.

100 See National Health and Medical Research Council, *The Australian Immunisation Handbook*, 8th edition, Canberra 2003, pp. 60, 61.

101 Stephen J Gluckman, 'Prevention of malaria in travellers', *American Family Physician*, 1 August 2003, p. 3.

2.57 In addition, the possibility of transmitting some diseases such as TB to others including family members, is heightened through absence of early identification. Although reference was made to prophylaxis for malaria, the ADF does not support BCG for preventing TB: 'the ADF will seek to minimise the impact of TB infection through targeted screening'.[102] It does not appear from information provided that the post deployment period is used to complete a vaccination program, including for anthrax, although this may not be the case. However, other evidence suggests that there may not be a standard process for providing immunisations by set dates, and that a catch–up process is used:

> The recommendation is that if there is a prolonged period between the vaccinations then you basically carry on as though that time gap did not exist. Say that, hypothetically, there are three vaccines in a suite of vaccines and that a person has had the first two, there may be a one or two–year gap, then you would only give the person the third shot and consider the sequence to be complete. You do not start from square one and start revaccinating.[103]

2.58 While many of the issues identified in submissions concern the difficulties experienced by individuals post deployment, the causal factors of many of these problems could be attributed in part to processes operating during the pre deployment stage and during the deployment period itself. In particular these concern absence or incompleteness of medical records; inadequate pre–deployment assessment; absence of adequate information on environmental and other hazards, especially those which are perceived as relating to slowly developing disorders; and some lack of clarity about the status of individuals relative to occupation—that is, that different activities may expose people to different risks.[104]

Environmental hazards

2.59 Although environmental/chemical exposures may have been identified just prior to return to Australia, it would be necessary for health examiners to be aware of these and of potential implications for future health. In addition, possibly inadequate levels of post–deployment health assessment may affect the capacity of the individual to identify problems in the short and long term, or to seek help for these.

> …in Bougainville we were exposed to a large number of chemicals that we are still not 100 per cent sure about the long-term effects of. When I was over there I never knew that was the case… all the ones associated with mining copper and gold. We are still not 100 per cent sure. We have a large list of chemicals that we were exposed to.[105]

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102 See *Submission* 9, Defence Organisation, Attachment D, ADFP 1.2.2.1, *Immunisation Procedures*, paragraph 5.80.

103 *Committee Hansard,* p. 63. See also Appendix 3.

104 See *Submission* 8, Repatriation Commission, p.15, paragraph 73.

105 *Committee Hansard*, p. 42 Australian Peacekeepers & Peacemakers Association.

2.60 The extent of exposures to substances such as depleted uranium (*du*) and smoil *(smoke and oil)* would be known to some degree, with land troops generally being more vulnerable than those on ships.[106] Although current information suggests there is limited long term effect of *du*, this prediction is made only on the basis of work undertaken on those who served in the first Gulf War: fourteen years is not a particularly long period to assess effects which may not manifest for two or three decades. It is the view of Defence witnesses that Australian personnel were not exposed to significant levels of *du*,[107] although a survey of personnel from the 2nd Gulf War will also be carried out. DVA's opinion on *du* is similar to that of Defence, that there are likely to be limited effects.

> There are no known health effects of depleted uranium in humans. What is suspected is that it might result in renal damage in the longer term. This is because in studies of laboratory animals, uranium given in high doses results in renal damage. It is also envisaged that there may be a risk for cancer, as DU is a weak emitter of alpha particles. However, this risk of increased cancer has not been actually observed in any population of humans that have been exposed to DU. Thus, we do not know if there is any level of DU related disease. Moreover, at the exposure level that we believe Australians experienced it would be difficult to envisage that there would be any adverse effects.[108]

2.61 Although some testing was eventually introduced for persons who had been exposed to *du* in the first Gulf War, it apparently was not made available to those who were not current members of the ADF.[109] However, Defence advised that:

> 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.[110]

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106 *Submission* 8A Repatriation Commission/Department of Veterans Affairs, p. 7. 'DVA understands that for a brief period in the 1980s, certain Australian close-in air defence systems used on Royal Australian Navy ships used depleted uranium. Depleted uranium is also used in a wide variety of industrial applications such as in drills in engineering and in early Boeing 747 aircraft. Given this, Australia has been broadly aware of the potential for exposure to DU since the early 70s, although it has not been seen as a matter of particular concern until the years after the 1990–91 Gulf War.'

107 Budget estimates, FADT, 4 June 2003, p. 369. See also Chapter 4.

108 *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 6.

109 See Budget estimates, FADT, 4 June 2003, p. 369, Budget Supplementary Estimates, FADT, 5 November 2003, p. 27, Additional Estimates, FADT, 18 February 2004, pp. 99–100.

110 *Submission* 9B, Defence Organisation, p. 4, Q2(h), *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 7: 'It should be noted that the levels of uranium in exposed persons decreased with the passage of time, thus with so many years since the Gulf War, it may be that urine testing has limited or even no value'.

2.62 Defence noted that the levels of exposure are risk of either (a) increased cancer rates or (b) kidney damage from the toxicology would at worst be twice that of the baseline population'.[111] This may be so, and also considered to be well under the amount necessary for an effect on health, but as one of the concerns of 1st Gulf War veterans appears to be the *combined* effects of various exposures and vaccinations, such statements may not produce much confidence.

2.63 Given the fact that many concerns develop and grow out of proportion to actual risk—as far as such risk is known—it would be more appropriate for services such as *du* testing to be made readily available. Even on a cost–effective basis, the reduction of fear and the belief that one's needs had been recognised is likely to reduce later claims. Some recognition of the effects of confusion and anxiety that arose from the problems with the anthrax vaccine is evident,[112] and this suggests that the way in which issues are handled, as well as the issue itself, is acknowledged as important.[113]

2.64 According to evidence, there is now available improved information on environmental exposures during conflict, at least in those areas which were monitored by the US:

> The US military has had a very robust system of putting environmental people on the ground to conduct routine soil, water and air sampling and they are linking that with geospatial data information so they are able to identify where an individual is at any point in time and what environmental threats were at play in that location, even down to things like overlaying satellite imagery to show the presence or absence of oil fire smoke plumes. We have access to that data for our deployed personnel…[114]

2.65 On occasion, information provided about the existence of environmental threats can also be used to avoid having personnel working in certain areas, thereby reducing hazards.[115] However, the information available about areas where US troops were not present may be limited.

2.66 Additionally, the remarks made by various US reports[116] suggest that a number of important procedures were not undertaken in the collection of data which could limit the availability of information on exposures in conflicts, reports on which Australia may be dependent. The fact that processes are available, therefore, does not mean that these have been followed or that relevant data have been obtained.

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111 Budget estimates, FADT, 4 June 2003, p.369.

112 Budget estimates, FADT, 4 June 2003, p. 371.

113 See also above, Chapter 1, paragraphs 1.46 and 1.75–1.77

114 Budget estimates, FADT, 4 June 2003, p. 368.

115 Budget estimates, FADT, 4 June 2003, p. 368.

116 See above, paragraphs 2.3–2.5.

Psychological hazards

2.67 Psychological problems in particular were identified as a sensitive area, in spite of substantial advances made by both departments in the awareness of such problems and in the development of research and programs.[117] Psychological assessment following deployment did not appear to be detailed, at least in respect of Iraq, where part of the above–mentioned health briefing included some assessment.[118] Comments from one submission in particular stated that in the past and even more recently, 'the … regime of debriefings is inconsistent, and the quality is arbitrarily dependent upon resource availability.'[119] One detrimental aspect of former debriefings was the process of asking groups if there were issues to be discussed, which tended to restrict the volunteering of concerns in public.[120] Nonetheless, post 1995–96, more personal individual debriefings were thought to have been pursued, although this might not be until six months after return from deployment.

2.68 Defence did not agree with the assessment that the mental health of younger veterans was not understood, nor that there were ongoing problems with the majority of persons who had experienced some psychological problems:

> For those who are affected, most will find that the psychological symptoms are transient and will result in no long-term adverse outcomes.[121]

2.69 The screening used after the Iraq conflict appeared to be 'a psychological screening tool'[122] which required identification by the individual of 'exposure to what is potentially a traumatic event':[123]

> The tool that we are using is a questionnaire. As I mentioned earlier, it looks at two things. Firstly, it looks to see whether the individual has perceived that they have been exposed to an event that is significantly outside their expectation or their normal experience—in other words, something to which they may adversely react. Secondly, it then looks at how they are responding to that, because we all know there is enormous individual variation—an event which may be quite traumatic to one individual may in fact be deemed quite normal or quite acceptable to another. So it is a broad-brush screening tool that works in two ways.

117 See below, Chapter 3, paragraphs 3.32–3.34 and Chapter 4, paragraphs 4.5, 4.34, 4.35, 4.45, 4.51–4.54.

118 Budget estimates, FADT, 4 June, 2003, p. 359, General Cosgrove: 'Prior to departure from the Middle East all ADF members were examined by a medical officer and debriefed by a military psychologist.' See also p. 362.

119 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 3, paragraph 13.

120 *Submission* 6, Australian Peacekeepers & Peacemakers Association, p. 3, paragraph 12.

121 *Submission* 9B, Defence Organisation, p. 8, Q5(a).

122 Budget estimates, FADT, 4 June 2003, p. 360.

123 Budget estimates, FADT, 4 June 2003, p.361.

> Firstly, it gathers data, which works as a base line for the individual. Also, in a sense it is an education tool because it makes the person aware of what the potential range of symptoms are. Following the administration of that tool, they are then interviewed by a psychologist and given an opportunity, in quite an unstructured way, to discuss any concerns that they may have. That is an important part of the interaction. Firstly, it may pick up those people who are not being entirely honest or forthright in their questionnaire. Secondly, it also establishes a degree of personal rapport between the member and a psychologist so that hopefully the door is seen to be open if any problems develop later on.[124]

2.70 Again, a certain amount of onus appears to be on the individual to identify issues which they may not always be in a position to do. Nor may the assessment be any more valid through being completed prior to return 'when their thoughts are fresh',[125] since a traumatic event may have occurred long before. It was also noted that disorders such as PTSD must exist as a set of symptoms 'for a period in excess of six months before you can use that label'[126] which indicates it would be preferable to ascertain symptoms as soon as possible.

> Returning from overseas deployment without any counselling or intervention by a mental health professional can sow the seeds of long term mental health problems in traumatised personnel. It has been suggested that immediate treatment of combat–induced stress will reduce the likelihood, or at least the severity, of post–traumatic stress disorder. Early intervention is effectively a preventive strategy. Interventions before or immediately after developing stress symptoms promote an adaptive response to trauma and prevent maladaptive responses that lead to long term mental health problems.[127]

2.71 There are no doubt benefits and disadvantages to the current approach, and to the provision of information to the families of personnel so that they can check for changes in behaviour etc on a return from deployment.[128] Nonetheless, it seems more

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124 Budget estimates, FADT, 4 June 2003, pp. 360–361, see also *Committee Hansard*, p. 81: 'The issue is then reinforced when we do the post deployment medical screening: the medical officers are invited to ask open ended questions such as, 'Are there any of the above or is there anything else you would like to share with me?' Other than that, unless the person presented to a health care provider whilst they were deployed and said, 'I am here to see you because I have just had a near death experience,' or, 'I am upset because I witnessed such an event,' the only way we have to do that is through more formal things such as patrol logs or contact logs or that sort of thing. But I freely admit that there are many possible scenarios where someone may be exposed to a significant event and that event may not be recorded in real time. I can think of examples from Rwanda that I was made aware of'.

125 Budget estimates, FADT, 4 June 2003, p. 362.

126 Budget estimates, FADT, 4 June 2003, p. 361.

127 Karl L Haas, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 4 (1) 2003, pp. 19–22.

128 Budget estimates, FADT, 4 June 2003 p. 361: 'they are encouraged to provide that document to their spouses or partners or family members'.

efficient and professional for the ADF itself to do this, and within a shorter period than three months after return.

2.72 This is not to deny that families in the general community who have a member with serious mental illness will necessarily become more involved in monitoring, once a diagnosis has been made. However, it seems outside the current community standard to place a responsibility on partners or parents (who may not see much of their children) to make an assessment that is properly made at the least by an experienced psychologist. Even though 'leaders' and 'senior personnel' are also educated in the identification of symptoms of mental illness,[129] they will need to have support from other staff in this process—leaders and senior personnel may not have the ongoing contact which could help identify changes in behaviour.[130]

> It should be noted that stress is additive and that post-deployment issues such as readjustment to civilian life, relationship difficulties, financial hardship etc may contribute significantly more to the veteran's health than the original service–related stressor. While stressors can be identified in post–deployment checks there is a need for veterans to accurately report their health status. Sometimes this is not done, especially if the serving member believes it may lead to an early end of their career in the military.[131]

2.73 That there have been changes which have increased available information, and which are directed to improving services generally, is apparent. Health service provision includes regular collection of data on Key Performance Indicators (KPI) relating to issues such as patient satisfaction, vaccination levels, and deployable status.[132]

> 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.
>
> 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

129 Budget estimates, FADT, 4 June 2003, p. 363.

130 See also below, Chapter 4, paragraphs 4.64–4.68.

131 *Submission* 8A, Repatriation Commission/ Department of Veterans' Affairs, p. 12.

132 Joint Health Support Agency, DJHSA Directive 04/02, 17 May 2004, *Collection of Key Performance Indicators*, pp. 2–3.

> mostly aligned to civilian standards as determined by the *Report on Health Sector Performance Indicators 2001,* Queensland Health, Brisbane.[133]

2.74 The development of a Mental Health Strategy for the ADF indicates that there is a good awareness of mental health issues: 'mental health issues are a significant by–product of involvement in both peacekeeping and warlike activities',[134] although some aspects of mental health services are not yet meeting needs.[135] There have been some advances in data collection and plans for improved medical records, although the electronic systems on which these will be based are not yet complete.[136]

The role of the individual and the family in deployment health

2.75 Regardless of whether a health service is home based or deployed, it has to meet both individual and group needs. Some of the evidence provided to the Committee indicated that there was quite a high level of responsibility placed on individuals in the ADF to maintain their health status and remain aware of potential problems in the future which might arise from deployments. It could be argued that this level sometimes demands too much of the individual, for, while responsibility for one's own health is a message increasingly promulgated in the community, it is not always possible for those within an institutional setting to be in control of health information and action.

'Medical' Staff in the ADF

2.76 It is more important for personnel on deployment to have confidence in the quality of 'medical' staff that are available. The role of doctors as opposed to other health staff in 'medical' work in the ADF is not clearly defined. While JHSA staff undertake the assessments made prior to and after deployment, the requirement for doctors in such assessments needs to be determined. The Defence submission refers to 'medical officers' having to sign off on pre–deployment checks,[137] although other evidence states that this medical assessment involves 'a questionnaire and a focused examination from a medical officer.'[138]

2.77 In the 1997 audit of non–deployment health services, the ANAO noted problems experienced with respect to the employment of medical staff.

> The ADF relies, almost exclusively, on Reserve members to provide specialist medical services during exercises and deployments. In view of the operational requirement for specialists, there was scope for employing

133 *Submission* 9B, Defence Organisation, p.4, Q2(e) and (f).

134 Budget estimates, FADT, 4 June 2003, p. 363.

135 Budget supplementary estimates, FADT, 5 November 2003, pp. 104–105.

136 See below, Chapter 3, paragraphs 3.6–3.21.

137 *Submission* 9, Defence Organisation, pp. 4–5, paragraph 21.

138 Budget estimates, FADT, 4 June 2003, p. 367.

> specialists full–time in the ADF. This could help alleviate the ADF's difficulties in attracting and retaining medical officers. Defence would need to compare the costs and benefits of engaging specialists under such a proposal with the usual methods of engaging them. In common with most career structures in the ADF, the higher ranks in the health services largely entailed command and associated management responsibilities. As a consequence, promotion to higher ranks in the health services largely resulted in health professionals spending more time on management and less time on clinical duties. A Defence review found that 45 per cent of doctors would prefer to confine their work to clinical duties.[139]

2.78 By the 2001 follow–up audit, there had been some progress with respect to the recommendation concerning a revised career structure and pay scale.[140] The situation affects mostly non–deployment services as higher level care during deployments is generally provided by other forces.

2.79 In deployments, the level of health staff available for level 1 care appeared not to be a medical officer, which may contribute to limited information being available on more complex issues:

> The health plan for Iraq was that each of the units deploying would have embedded what we call level 1 health support, which is not always a medical officer. In the case of a naval unit, that may be an advanced medical assistant, called a phase 4 medical sailor. In the case of Army units, it could be an advanced medical assistant or it could be a medical officer; it would depend on the size of the unit and where it was operating. But the intention was that all ADF units would have access to their own primary health care. Level 2 and level 3 health care support was provided by coalition partners.[141]

2.80 Primary health care was also addressed in the 1997 and 2001 reports by ANAO, which had originally recommended that there be greater access to relevant work experience by ADF personnel:

> Although the primary role of ADF health services is to support operational forces in combat situations, health staff had insufficient training and experience in treating trauma (wounds) and emergency cases, which are the kind most likely to occur in such situations. The greatest scope for obtaining this type of training and experience was in civilian hospitals and

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139 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow-up Audit, Department of Defence,* 2001, paragraph 3.14.

140 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow-up Audit, Department of Defence,* 2001, paragraph 3.24: 'Overall, the ANAO found that progress on Recommendation No.7 had been slow but that Defence has examined the medical officer structure. The proposed salary and career structures, once implemented, should provide greater flexibility, improve operational effectiveness and assist in retaining ADF medical officers'.

141 *Committee Hansard,* p.87—level 2 and 3 health care is *in patient* care.

ambulance services. Lack of civilian recognition of ADF training of medical assistants posed a difficulty in arranging placements with the civilian sector.

1997 Recommendation No.10*

The ANAO recommends that Defence make determined efforts to reach agreement with the necessary civilian health authorities for ADF personnel to work in areas where they will be exposed to emergency treatment of wounds and injuries and that a uniform ADF policy be developed. [142]

2.81 In the 2001 follow-up audit, it was reported that the situation had not changed substantially, for several reasons including the number of deployments in which staff had been involved.[143] However it is possible that practical experience in the field may also have improved the skills of such staff.

2.82 Other ADF material distinguishes medical officers from contract doctors, and also uses the terms 'health officer', 'health practitioner' and 'practitioner', the last three seemingly interchangeably.[144] All three terms appear to mean 'doctor'. An alphabetical list of 'medical' staff[145] included a 'medical scientific officer and 'doctor', but no 'medical officer'. There also appears to be quite a high turnover rate of 'medical' staff, and although data were not readily available on the reasons for

142 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 4.15.

143 Australian National Audit Office, Report No. 51, 2000-2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 4.16: 'The situation has not changed significantly since the original audit. Although a strategic alliance between 1st Health Support Battalion (1HSB) and Liverpool Hospital has been in operation since 1998, there are no alliances between other ADF health units and civilian hospitals. Defence advised that strategic alliance proposals were being discussed with a number of civilian hospitals including, a major Brisbane hospital, Royal North Shore Hospital and Westmead Hospital. The ANAO was advised that progress in making such agreements with civilian health authorities had been slow due to health personnel shortages and the high number of recent ADF operations in which the DHS has been involved. See also *Submission* 5, Regular Defence Force Welfare Association Inc, p. 2.

144 Joint Health Support Agency, DJHSA Directive 03/03, 25 March 2003*, Guidelines for Accurate and Legible Clinical Records*. See also DJHSA Directive 10/04, 7 April 2004, *Orientation of Contract Health Practitioners Working on Australian Defence Force Bases*

145 Additional estimates, FADT, 18 February 2004, Answers to Questions on Notice, Defence, part 2, p. 69: 'Assistant Dental/Dental Assistant, Dental Hygienist, Dental Technician/ Technician Dental, Dentist, Doctor, Environmental Health Surveyor, Environmental Health Officer, Examiner Psychological, Laboratory Officer, Laboratory Technician/Tech Lab, Medic/Medical Assistant, Medical Administrator, Medical Scientific Officer, Nurse, Pharmacist, Physical Training Instructor, Radiographer (Officer), Radiographer (Soldier), Technician Operating Theatre, Technician Preventive Medicine, Therapeutic Officer (Physio)'.

departure, it is assumed that the majority of such staff were not dismissed but chose to leave.[146]

2.83 Separation rates for ADF medical staff for 2001–02 and 2002–03[147]

Separations 2001–2002			**Separations 2002–2003**		
Navy	Army	Air Force	Navy	Army	Air Force
11.2%	12.4%	14.1%	14.8%	9.3%	11.5%

2.84 While it is likely that many persons will seek a rotation in the ADF for experience, it seems unlikely that the majority of 'medical' staff employed by the ADF will have had considerable experience within their own profession and even less likely to be at the head of it, unless they are a member of the reserve forces. The question therefore needs to be asked if there are sufficient staff with experience and qualifications available within the ADF,[148] especially because of the increased reference to mental health procedures, pre-deployment psychological assessment, and post-deployment evaluation of psychological problems or potential problems.[149]

2.85 It is also important to ensure that those who are working in the ADF are able to remain sufficiently independent of what might be seen as military objectives as distinct from 'medical' objectives. This is likely to be difficult when there is a clash between the principles of one profession and the other. For example, mention has been made of the alleged efforts of the 'medical officer' and the psychologist on board the *Kanimbla* to persuade personnel to accept the anthrax vaccination.[150] This can lead to situations where the professional skills are being misused to meet other objectives. Once the basic information is provided, any 'persuasion', if acceptable, should be carried out by some other person outside the medical unit.

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146 Additional estimates, FADT, 18 February 2004, Answers to questions on notice, Defence, part 2, p. 69.

147 Additional estimates, FADT, 18 February 2004, Answers to questions on notice, Defence, part 2, p. 69.

148 See above, paragraph 2.7 where Defence notes the difficulties experienced in obtaining sufficient numbers of qualified staff.

149 'A major limitation in the delivery of mental health services to the ADF identified in the ADF Health Status Report (2000) was the lack of integration between service providers. There are a number of organisations within Defence that deliver comprehensive mental health services, but due to a lack of integration they sometimes work at best in parallel and have the potential to work in opposition,' www.defence.gov.au/dpe/dhs/mental health. Mental health teams which have been established as part of the ADF Mental Health Strategy include 'doctors, psychologists, social workers and nurses,' see www.defence.gov.au/dpe/dhs/mental health/publications

150 See Appendix 3. Details of this alleged persuasion are not provided, and therefore it cannot be discussed further.

2.86 As the major role of providing support to the injured and conducting post deployment screenings is carried out by JHSA[151] its staff would be expected to be aware of a range of factors relevant to immediate and longer term rehabilitation. The skills and qualifications of such staff should therefore be appropriate to this task. Psychologists are also provided on site prior to return from deployments, and are involved in the administering of questionnaires designed to elicit information about PTSD in particular. Given that one of the reasons for the use of questionnaires was to build up a relationship which may need to be utilised later, it is assumed these same psychologists are involved in any further assessment or service provision, although staff turnover may limit this.

2.87 Some problems may also be difficult to identify, and require input from individual personnel, who are issued with a card which lists diseases endemic in the area of deployment which is to be used as a prompt in the post deployment review.[152] How effective these cards are may depend on the time available to JHSA staff and whether they are qualified to ask appropriate questions that elicit information not readily forthcoming.

2.88 To some extent, responsibility during the post deployment period of assessment and screening is also placed on individual personnel. Defence states that 'individuals are given the opportunity to discuss any concerns with health staff',[153] but, as suggested above, the usefulness of this process would need to be assessed. Some submissions said the post deployment de–briefing process was inadequate and would not encourage the identification of problems, quite apart from the broader sensitivity to being seen as vulnerable or unable to cope:

> I think there is also a culture within Defence and even within the general community, as can be seen by things like the recent advertising and information campaigns on aspects like depression, that means there is a stigma associated with mental health issues. A culture such as that in Defence, or the uniformed element of Defence, makes it quite difficult to discuss those sorts of issues. It makes it quite difficult to talk about them in general.[154]

2.89 Persons returning from deployment may not be in the best position to ensure that all issues are covered, and thus the effectiveness of information on mental health both pre and post deployment will depend very much on the extent to which there is an effective briefing and de-briefing. It has been suggested that many mental health issues may be those which personnel are unwilling to discuss, even though ADF

151 *Submission* 9, Defence Organisation, p. 3, paragraph 11.

152 *Submission* 9, Defence Organisation, p. 5, paragraph 24.

153 *Submission* 9, Defence Organisation, p. 5, paragraph 24.

154 *Committee Hansard*, pp. 32–33, Australian Peacekeepers & Peacemakers Association.

members can have access to treatment and management for any mental health problem irrespective of its cause.[155]

2.90 There is little evidence, overall, to demonstrate that placing a certain level of responsibility on the individual will always be the most effective way of ensuring issues are identified and able to be expressed. In theory, individual responsibility is part of the community standard, in that the greater availability of information and the provision of a wide range of health programs advertised and supported by state and commonwealth governments has made health a much more individual issue. Risk factors for disease, obesity, smoking and other campaigns have made potential health problems much more widely known. The capacity to act on these, however, will vary.

2.91 Insofar as deployments are considered welcome, there is an incentive for ADF personnel to remain fit, although it could also be said there is also an incentive to hide or minimise problems that might limit access to deployment. Quite apart from the identified issue of not having information on injuries or conditions for which compensation may be being paid, the ADF culture may not encourage identification of some problems and the individual may lack the skills to identify these as matters which must be addressed. It is possible therefore that greater availability of experienced doctors in some assessments is required, regardless of the emphasis on choice, awareness and responsibility.

Occupational/Employment Health

2.92 While much recent effort has been placed on the fitness of personnel for deployment, the ADF has also acknowledged that occupational health is a priority that is being addressed:

> 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.[156]

2.93 This approach reflects the previous high rate of injury and level of disability in the ADF, an important factor in whether it is possible to provide fit personnel for deployment.

> 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

155 *Submission* 9B, Defence Organisation, p. 8, Q5(e).

156 *Submission* 9B, Defence Organisation, p. 4, Q2(g).

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 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 (%)	
1994–1995	23
1995–1996	17
1996–1997	15
1998–1999	5
2002–2003	13
2003–2004 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. [157]

2.94 While the emphasis on healthy lifestyle is essential, a limited regard by the ADF to occupational/employment stresses also leaves individuals in a work environment where they are unable to control the factors which affect their career. Problems with injury rates were identified in the 1997 ANAO report.

> The original audit commended Defence's initiatives to reduce recruits' injuries and wastage but found little evidence of research on the incidence and cause of injuries more generally, especially in Army where the major problems occurred. Full direct and indirect costs associated with injuries in the ADF were not recorded or known, apart from identified post–discharge costs (for example, lump sum compensation payments). Individual ADF programs did not have to fund the premiums paid by Defence to cover compensation costs, and therefore there was no incentive for program managers to reduce injuries leading to compensation claims.[158]

2.95 The 2001 follow–up audit reported that there had been some progress in three key areas, including injury prevention.

157 *Submission* 9B, Defence Organisation, pp. 6–7, Q4.

158 Australian National Audit Office, Report No. 51, 2000–2001, *Australian Defence Force Health Services Follow–up Audit, Department of Defence*, paragraph 7.1.

> Short–term strategies aimed at reducing injuries in the ADF since the original audit had been limited to reducing injuries amongst recruits. The ANAO commends the work carried out in relation to injuries among ADF recruits and notes that savings in both personnel and costs that have been achieved. Nevertheless the ANAO considers that there is scope for short-term strategies to be developed and implemented with application to the wider ADF population, based on the findings of studies completed at the time of the original audit. For example, it has been known, from as early as 1991, that sport and physical training are the two main causes of injuries in the ADF. Implementation of short–term strategies in these areas would have led to earlier personnel and monetary savings. [159]

2.96 In 2000, the first ADF health status report made very similar comments, although these were based on 1997 data.

> Physical training is linked to the highest number of working days lost, hospital admissions, sick and light duties days. Sporting injuries are another significant factor.
>
> The study shows that physical fitness and military training injuries are higher within the part–time Reserve forces. The new Injury Prevention Strategy will focus on initiatives aimed at minimising these injuries across the ADF, including part–time forces.[160]

2.97 Early reports on the Defence Injury Prevention Program suggest that it has had an effect, at least as far as recruits are concerned.

> The program was developed at a number of pilot sites covering 15 per cent of the full–time ADF population. Within the sample selected for pilot testing, the program has resulted in a 95 per cent reduction in rates of pelvic stress fracture for female Army recruits, elimination of serious knee injuries in recruits negotiating an obstacle course and ten to 45 per cent reduction in rates of injury in other ADF groups.[161]

Women

2.98 Two organisations referred to women, although not in great detail. The Australian Peacekeepers & Peacemakers Association[162] and the Regular Defence

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159 Australian National Audit Office, Report No. 51, *Australian Defence Force Health Services Follow–up Audit, Department of Defence***,** paragraph 7.9.

160 See also Peter S Wilkins, 'Occupational Health and Safety Challenges for the ADF', *ADF Health*, 5:1, 2004, pp. 1–2: 'By 2000, Defence's annual OH&S cost per uniformed member was almost 3 times that for comparable civilian employee groups. Commanders and supervisors at all levels are greatly concerned for the health and safety of their subordinates, but there is an obvious lack of means to give effect to their good intentions.'

161 Department of Defence, *Annual Report 2002–2003*, Chapter 5, Section: Performance Against People Matter Priorities for 2002–03, p. 424.

162 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

Force Welfare Association Inc[163] both mentioned the special needs of women personnel. They would be mostly among the category of younger veterans for whom the Australian Peacekeepers & Peacemakers Association would act, and therefore include women subject to the different pressures of peacekeeping as described by that organisation and others.[164] From the information provided on occupational injuries,[165] women were also especially subject to some of the injuries that occurred in training, although the development of new processes had improved the injury rate, and possibly the retention rate.

> There are obviously different injuries, in some cases, but if you are talking about the compensation or TPI support that we provide, we provide it equally. DVA are just as good to males and females—and Defence have an excellent equity program—and, if they were not, we would be the first ones to be supporting our members and putting in complaints. I think there are some injuries that possibly are more prone to be suffered by one sex than the other—we do not have the facts on that.[166]

2.99 It was also suggested that there may be different responses to deployment issues, including different stress reactions.

> We are aware, as a general rule—if you want to talk generalisations—that the response to stress is different between men and women. That is what we have been told. In our limited research, there is a difference. But remember, of course, that now we are getting more and more women in the Defence Force.[167]

2.100 There is not a great deal of information on women in Defence's Annual Report, although a number of projects have been established which directly and indirectly will have an impact on women, including a Gender Diversity Strategy, and an assessment of 'physical characteristics and performance capacity' that could 'optimise an individual's likely success in each employment category'.[168] As noted above, there has been some work undertaken on reduction of injuries in recruitment processes, but otherwise it is not readily apparent that special attention is paid to physical health needs.

2.101 Both workplace harassment and bullying have also been addressed by the ADF,[169] although a more detailed report would be required to determine the extent to

163 *Committee Hansard*, Regular Defence Force Welfare Association Inc, p. 12.

164 See above, paragraph 2.37, and see also Karl L. Haas, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 4 (1) 2003, pp. 19–22.

165 See above, paragraph 2.97.

166 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

167 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 43.

168 Department of Defence Annual Report 2002–2003, p. 432.

169 Department of Defence Annual Report 2002–2003, pp. 426, 430.

which women were subject to harassment and bullying and if this, as well as deployment issues, contributed to mental health problems and required specific services.

Reservists

2.102 Reservists were also a particular concern for organisations who believed they were at special risk of not obtaining required services.

> …it seems that reservists are a class of members of the ADF who, when they complete their period of service, go back very quickly to the civilian health system. Particularly if they think they are suffering from conditions that they are not quite sure about, their only access to health treatment is through practitioners in the civilian sector who may or may not be aware of the peculiar problems of that deployment.[170]

2.103 A similar point was made by another organisation which had been set up to assist younger veterans—including those who might undertake further deployments—to obtain holistic health treatment.

> … when our young veterans leave the Australian Defence Force they no longer have access to Defence's safety network. As soon as a young veteran leaves Defence, they are alone, facing both medical and health issues without Defence's help. The young veteran views the Department of Veterans' Affairs with scepticism and fear if they have not actually worked for them on a regular basis, and see them as only dealing with compensation.[171]

2.104 If reservists are not part of the post-deployment processes, including health checks, they are at risk of obtaining limited appropriate health services for a number of reasons, including not being fully aware of the risks experienced and not having the skills to identify other issues including mental health problems. Some of these issues may be picked up later if they go on further deployments, but even if this is the case, the delay in identifying a problem may have contributed to its becoming more entrenched.

2.105 In some instances, reservists will be eligible for DVA health care cards.[172] DVA also advised that efforts were made to provide required care and obtain specialist services where necessary.

> DVA understands that there is a shortage of specialist and expert medical skills in Australia in many areas, but efforts are made to ensure that returning reservists have all of their needs met. It is in the nature of reserve

170 *Committee Hansard*, Regular Defence Force Welfare Association Inc, p. 5.

171 *Committee Hansard*, Australian Peacekeepers & Peacemakers Association, p. 28.

172 *Submission* 8A, Repatriation Commission/Department of Veterans' Affairs, p. 2: 'Where a reservist is eligible for health care from DVA, they have access to the arrangements pertaining to DVA's White or Gold Card, as appropriate'.

> service that reservists are often difficult to get in contact with professionals with the appropriate skills. This has been a known problem for many years, both in Australia, the United States and the United Kingdom. Each country uses a variety of strategies to try to ensure that the health needs of reservists are met, and there is a regular exchange of information about this problem.[173]

2.106 Insofar as reservists include people with peacekeeping experience, they may have a particular need of services which understand the special pressures that can occur in this type of work. Such services may not need to diverge markedly from those available to others whose deployment has involved peacemaking and active combat, although assessment of needs should be undertaken by experienced researchers and staff.

173 *Submission* 8A, Repatriation Commission/Department of Veterans Affairs, p. 2.