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Australian Government

Department of Defence

HST/OUT/2004/125

The Secretary
Senate Foreign Affairs, Defence and Trade References Committee
Suite S1.57
Parliament House
CANBERRA ACT 2600

REPONSES TO QUESTIONS ON NOTICE SENATE INQUIRY HEARING INTO THE EFFECTIVENESS OF THE MILITARY JUSTICE SYSTEM

1. Attached is the Defence response to questions taken on notice from the Chairman of the Senate Inquiry into the Effectiveness of the Military Justice System.

2. In accordance with Departmental practice the responses have been cleared by the Minister Assisting the Minister for Defence.

R. B. Treloar
Air Vice-Marshal
Head Senate Taskforce
Military Justice Inquiry

Tel: 02 6265 4145
R8-2-50

30 July 2004

Enclosure:
1. Reponses to Questions On Notice Senate Inquiry Hearing into the Effectiveness of the Military Justice System

SENATE FOREIGN AFFAIRS, DEFENCE AND TRADE REFERENCES COMMITTEE INQUIRY INTO THE EFFECTIVENESS OF THE MILITARY JUSTICE SYSTEM

QUESTIONS ON NOTICE 21 June 2004

ADF Mental Health Screening

QUESTION 1 **ACTION AREA: DMH**

Senator Hutchins

Hansard: page 17

Please provide copies of the ADF Mental Health Screen form and the associated assessing instructions.

RESPONSE

The attached Health Bulletin No 9/2003 provides details on the ADF Mental Health Screen and its interpretation.

Granting of Leave on Medical Grounds

QUESTION 2 **ACTION AREA: DMH in consultation with DPE**

Senator Hutchins

Hansard: page 17

Please provide the requirements for granting leave on a recommendation from a health service provider.

RESPONSE

Granting of leave is a command responsibility vested in a member's commanding officer. In the case of members temporarily unfit for duty, granting of leave is based on a recommendation from a medical officer to the member's commanding officer. The commanding officer then decides whether to accept the medical officer's advice before approving/not approving the recommended sick leave.

If a member is hospitalised in an ADF medical facility, they are formally transferred under the command of the commanding officer of that facility. Accordingly, the commanding officer of that facility would become the approving authority for any leave taken by an individual whilst attached to the medical facility.

Suicide Prevention

QUESTION 3 **ACTION AREA: DMH**

Senator Hutchins

Hansard: page 23

Does training for officers involved in suicide prevention for indigenous soldiers include a video on black deaths in custody?

RESPONSE

No training provided by the Defence Health Services Branch includes the video on black deaths in custody.

Cadet Enhancement Program

QUESTION 4 **ACTION AREA: DGCADETS**

Senator Hutchins

Hansard: page 57

What types of cadet-initiated activities are being proposed under the Cadet Enhancement Program?

RESPONSE

The Cadet Initiated Activities program was introduced by the then Parliamentary Secretary to the Minister for Defence, Fran Bailey, in 2002.

Under the Cadet Initiated Activities program, Defence Force Cadets generate proposals and submit bids for funding on behalf of their unit to undertake activities that further their leadership and teambuilding skills. Cadets may also submit bids for training equipment they believe will benefit their unit.

Some of the successful bids submitted over the past couple of years include flight simulation software, adventurous training, kayaks, GPS equipment, and Unit visits to various Defence sites including the Australian Defence Force Academy.

An amount of $500,000 will be made available for Cadet Initiated Activities in FY 2004-05 via the Cadet Enhancement Program.

DEFENCE

DIRECTOR–GENERAL DEFENCE HEALTH SERVICE

HEALTH BULLETIN NO 9/2003

Note: Director-General Defence Health Service Health Bulletins are produced to disseminate Health Information. They are to be filed in a separate binder, readily accessible to all staff. They remain in effect until cancelled in accordance with instructions in the Bulletin. Publications can be accessed on the Defence Intranet at http://defweb.cbr.defence.gov.au/home/documents/adfdocs/healthindex.htm

12 AUGUST 2003

AUSTRALIAN DEFENCE FORCE MENTAL HEALTH SCREEN

Introduction

1. Successful evaluation and treatment of psychological symptoms and emotional distress rely upon a thorough and objective assessment. The Australian Defence Force (ADF) Mental Health Screen is a component of the investigative or diagnostic process but does not take the place of a thorough and systematic clinical interview, psychiatric history and mental state examinations. Essentially, the ADF Mental Health Screen is a tool that provides valuable diagnostic information that assists in the evaluation of psychological symptoms or emotional distress. Furthermore, the screen can assist with the formulation of an appropriate management plan, and will also, once administered for a baseline first time, allow for reassessment of an individual's condition and/or response to treatment.

Aim

2. The aim of this Health Bulletin (HB) is to outline the content of the ADF Mental Health Screen and describe its administration, scoring and interpretation.

Scope

3. This HB does not specify when mandatory administration of the ADF Mental Health Screen is to occur. Mandatory administration details are outlined in relevant instructions. However, the ADF Mental Health Screen can be administered at any time when a health or mental health professional feels that the diagnostic and/or treatment process would be assisted by its use.

Australian Defence Force Mental Health Screen

4. The ADF Mental Health Screen consists of the following brief psychometric scales:

a. the Kessler Psychological Distress Scale—10 (K10);

b. the *Post-traumatic Stress Disorder Check List—Civilian* (PCL–C); and

c. the Alcohol Use Disorder Identification Test (AUDIT).

Each scale will be addressed separately in this HB.

KESSLER PSYCHOLOGICAL DISTRESS SCALE—10

General

5. The K10 is a scale measuring non-specific psychological distress. It was developed in 1992 by Kessler and Mroczek as a short dimensional measure of non-specific psychological distress in the anxiety-depression spectrum, for use in the United States National Health Interview Survey. The K10 has been used in a number of population surveys in Australia, such as State-based surveys and the National Mental Health Survey conducted in 1997 by the Australian Bureau of Statistics. It has also been used in all national surveys in the World Health Organisation's (WHO) World Mental Health Initiative.

6. The scale consists of ten questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms a person may have experienced in the four weeks prior to interview. The scale yields a measure of psychological distress based on questions about negative emotional states experienced by respondents.

Comparison between Kessler Psychological Distress Scale—10 and other measures

7. Research has revealed a strong association between high scores on the K10 and a current Composite International Diagnostics Interview (CIDI) diagnosis of anxiety or affective disorders. Sensitivity and specificity data analysis has indicated that the K10 is an appropriate screening tool to identify likely cases of anxiety and depression in the community. There is a lesser but significant association between the K10 and other mental disorder categories, or with the presence of any current mental disorder. The K10 has been found to have better overall discriminatory power than the GHQ–12 in detecting DSM–IV depressive and anxiety disorders.

Scoring

8. The K10 is a 10-item scale that has five response categories. A copy of the K10 is in annex A. Responses to the questions are scored from left to right in the following manner:

5 for *All of the time*
4 for *Most of the time*
3 for *Some of the time*
2 for *A little of the time*
1 for *None of the time*

The scores for each item are added to yield an overall score.

Interpretation

9. A set of cut-off scores for the K10 was developed by the Clinical Research Unit for Anxiety and Depression (CRUfAD), School of Psychiatry, University of New South Wales to determine the prevalence of anxiety or depressive disorders.

10. Scores range from 10 to 50, with the ranges shown below indicating the following:

a. People who score **10–15** report a low-level of psychological distress. They have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the CIDI. There is a remote chance of these individuals reporting a suicide attempt in their lifetime;

b. People who score **16–29** report a medium level of psychological distress. They have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder. They have a one per cent chance (three times the population risk) of ever having made a suicide attempt; and

c. People who score **30–50** report a high-level of psychological distress. They have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and six per cent chance (20 times the population risk) of ever having made a suicide attempt.

11. The first group in subparagraph 10.a. comprise 78 per cent of the population, and are unlikely to require any significant interventions. Groups in subparagraph 10.b. and c. are to be appropriately referred for more thorough assessment, and possibly treatment, if their distress is adversely impacting their quality of life. Psychologists are to refer to the appropriate technical instruction for further guidance on how to manage groups in subparagraph 10.b. and c. Finally, these groups should also be given information on self-help techniques and any support resources that are available to them.

POST–TRAUMATIC STRESS DISORDER CHECK LIST

General

12. The *Post-traumatic Stress Disorder Check List* (PCL) (Weathers, Litz, Herman, Huska and Keane, 1993) is self-report rating scale for assessing the 17 DSM–IV symptoms of PTSD. Three versions of the PCL are available, although the differences between them are small. The PCL–Military is a specific military version, with questions referring to *'a stressful military experience'*. The PCL–S is a non-military version that can be referenced to any specific traumatic event, with questions referring to 'the stressful experience'. The PCL–C is a general civilian version that is not linked to a specific event, with questions referring to 'a stressful experience from the past'. The PCL–C is the version currently used by the ADF as, at this stage, few ADF members are involved in prolonged combat operations, and are more likely to be exposed to traumatic events other than combat.

Validity and reliability

13. The PCL has excellent test-retest reliability over a 2–3 day period. Internal consistency is very high and the PCL correlates strongly with other measures of PTSD, such as the Mississippi Scale.

Scoring

14. The PCL is a 17 item scale that has five response categories (a copy is in annex B). The responses are scored left to right as follows:

1 for **Not at all**
2 for **A little bit**
3 for **Moderately**
4 for **Quite a bit**
5 for **Extremely**

A total score is computed by adding the scores on the 17 items, so that possible scores range from 17 to 85.

Interpretation

15. In Vietnam combat veterans a cut-off of 50 on the PCL was found to be a good predictor of a PTSD diagnosis. It is therefore recommended that respondents who score above or close to 50 on the PCL be appropriately referred for a more thorough assessment.

ALCOHOL USE DISORDERS IDENTIFICATION TEST

General

16. Hazardous or harmful levels of drinking are often undetected and many people may present to health care facilities with signs and symptoms that would not necessarily be linked to their drinking. Screening therefore is a simple way to identify people whose drinking may pose a risk to their health, as well as those who are already experiencing alcohol-related problems, including dependence.

17. Screening is extremely valuable as, given appropriate support and assistance, people who are not alcohol dependent may reduce or stop their consumption. However, once alcohol dependence has developed, cessation or changes to consumption are much more difficult to achieve and usually require specialised treatment. Not all individuals who are drinking at risky or high risk levels will become dependent, but no one becomes dependent without having first engaged for some time in consumption at those levels.

18. The AUDIT screening test was developed by the WHO as a simple method of both screening for hazardous and harmful use of alcohol and assisting in the formulation of brief interventions. It provides a framework for an intervention with hazardous and harmful drinkers that aims to reduce or cease their alcohol consumption. It also helps to identify alcohol dependence and some of the specific consequences of hazardous and harmful drinking.

19. The AUDIT provides an accurate measure of risk across gender, age, and cultures. Its validity, brevity and flexibility make it the most widely used alcohol-screening instrument around the world. The AUDIT is particularly designed for health care practitioners in a range of health settings. Furthermore, with suitable instruction it can be self-administered or used in other settings by non-health professionals.

Administration

20. The Interview Version AUDIT screen is to be administered by health and allied health professionals who have received appropriate training in the use of the tool. Training in the use of AUDIT will be coordinated and provided by the ADF Drug and Alcohol Program, Directorate of Mental Health. The version of the AUDIT to be utilised by Defence Health Service uniformed and contracted personnel when performing screening for hazardous and harmful alcohol use appears in annex C.

Scoring

21. The AUDIT consists of ten scored questions (questions 1–10). Two additional non-scored questions (questions 11–12) provide an indication of readiness or motivation to change and have been designed to assist in determining appropriate levels of intervention.

22. AUDIT questions are related to the following conceptual domains:

a. questions 1–3 ask about frequency and quantity of drinking and lie within the *hazardous alcohol use domain*;

b. questions 4–6 ask about impairment of control over drinking, salience of drinking and morning drinking. These questions lie within the *dependence symptoms* domain;

c. questions 7–10 ask about feelings of guilt, blackouts, injury and concern by others. These questions lie within the *harmful alcohol* use domain.

23. Scoring of AUDIT is a simple activity. Each of the questions 1–10 has a set of responses to choose from and each response has a value ranging from 0–4 (the number within parentheses). In the AUDIT—Interview Version, the interviewer enters the score corresponding to the response into the box beside each question. Then adds the scores from all the questions and records the answer in the box below question 10.

Interpretation

24. Total scores of 8 or more are regarded as indicators of hazardous or harmful alcohol use, or possible alcohol dependence. Higher scores indicate greater likelihood of hazardous and harmful drinking and may also reflect greater severity of alcohol problems and dependence.

25. More detailed interpretation of an individual's total score may be obtained by determining on which questions points were scored. In general, a score of 1 or more on questions 2 or 3 indicates consumption at a hazardous level. Points scored above 0 on questions 4–6 imply the presence or incipience of alcohol dependence. Points scored on questions 7–10 indicate that alcohol-related harm is already being experienced. The total score, consumption level, signs of dependence, and present harm all should play a role in determining how to manage an individual. Questions 9 and 10 should also be reviewed to determine whether there is evidence of a past problem.

26. Questions 11 and 12 are not scored. Responses to these questions indicate readiness or motivation to change, and assist the person administering the AUDIT to determine the most appropriate intervention.

Intervention

27. Individuals scoring 0–7 on AUDIT are regarded as low risk drinkers (or may be abstinent). Feedback affirming the low risk nature of alcohol consumption, and alcohol education, is appropriate. Provision of standard drinks health promotion material such as the *'Alcohol and Your Health'* booklet produced by the National Health and Medical Research Council is also appropriate. Copies of this booklet can be obtained through the ADF Drug and Alcohol Program.

28. Individuals scoring 8–15 on AUDIT are consuming alcohol in excess of low risk guidelines. A brief intervention using simple advice and health education materials is the most appropriate course of action. Focussing on immediate goals may allow for more immediate success in the treatment process, whatever the long-term goals may be. Immediate goals might include decreasing the frequency of drinking, maintaining an alcohol-free day or keeping a drinking diary. Where there is no opportunity to conduct an opportunistic brief intervention, the member should be provided with a *'Takeaway Intervention Pack*—TIP' for modifying alcohol consumption. TIPs for modifying alcohol consumption are packages containing a range of materials providing basic health information and practical approaches to cutting down drinking. TIPs are distributed to all ADF health and psychology facilities by the ADF Drug and Alcohol Program.

29. AUDIT scores of between 16–19 indicate hazardous and harmful levels of alcohol consumption. Hazardous and harmful use of alcohol can be managed by a combination of simple advice, brief counselling and continued monitoring by a health or allied health professional. Further diagnostic evaluation is indicated if the individual fails to respond to the intervention or if possible alcohol dependence is suspected.

30. AUDIT scores in excess of 20 indicate that the person falls into the high risk category of alcohol-related harm. Individuals scoring at this level are likely to be alcohol dependent and require more intensive intervention. Service providers should note that dependence varies along a continuum of severity and might be clinically significant at lower AUDIT scores. Individuals in this zone should be referred to specialist alcohol and other drug providers to consider withdrawal, pharmacotherapy and/or other more intensive treatments.

T.K. AUSTIN
Air Commodore
Director-General Defence Health Service

Annexes:
A. Kessler Psychological Distress Scale—10
B. Post–traumatic Stress Disorder check List—civilian
C. Audit—Interview version

DISTRIBUTION: DHS

SPONSOR: DMH

EARLIER HEALTH BULLETIN CANCELLED: Nil

REVIEW THREE YEARS FROM DATE OF PUBLICATION OR REVIEW

ANNEX A

KESSLER PSYCHOLOGICAL DISTRESS SCALE—10

35800

PSYCHOLOGY IN CONFIDENCE (After first entry)

K10

The following questions inquire about how you have been feeling over the last four (4) weeks. Please read each question carefully and then indicate, by filling in the circle, the response that best describes how you have been feeling.

	All of the time	*Most of the time*	*Some of the time*	*A little of the time*	*None of the time*
1. In the past four (4) weeks, about how often did you feel tired for no good reason?	○	○	○	○	○
2. In the past four (4) weeks, about how often did you feel nervous?	○	○	○	○	○
3. In the past four (4) weeks, about how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. In the past four (4) weeks, about how often did you feel hopeless?	○	○	○	○	○
5. In the past four (4) weeks, about how often did you feel restless or fidgety?	○	○	○	○	○
6. In the past four (4) weeks, about how often did you feel so restless that you could not sit still?	○	○	○	○	○
7. In the past four (4) weeks, about how often did you feel depressed?	○	○	○	○	○
8. In the past four (4) weeks, about how often did you feel that everything was an effort?	○	○	○	○	○
9. In the past four (4) weeks, about how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. In the past four (4) weeks, about how often did you feel worthless?	○	○	○	○	○

ANNEX B

POST–TRAUMATIC STRESS DISORDER CHECK LIST—CIVILIAN

PSYCHOLOGY IN CONFIDENCE (After first entry)

PCL-C

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and then indicate, by filling in the circle, the response that best describes how much you have been bothered by that problem ***in the past month.***

		Not at all	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1.	Repeated, disturbing *memories, thoughts* or *images* of a stressful experience from the past?	○	○	○	○	○
2.	Repeated, disturbing *dreams* of a stressful experience from the past?	○	○	○	○	○
3.	Suddenly *acting* or *feeling* as if a stressful experience from the past were *happening again* (as if you were reliving it)?	○	○	○	○	○
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?	○	○	○	○	○
5.	Having a *physical reaction* (e.g. heart pounding, trouble breathing, sweating) when *something reminded* you of a stressful experience from the past?	○	○	○	○	○
6.	Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	○	○	○	○	○
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	○	○	○	○	○
8.	Trouble *remembering important parts* of a stressful experience from the past?	○	○	○	○	○
9.	*Loss of interest* in activities that you used to enjoy?	○	○	○	○	○
10.	Feeling *distant* or *cut off* from other people?	○	○	○	○	○
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	○	○	○	○	○
12.	Feeling as if your *future* somehow will be *cut short*?	○	○	○	○	○
13.	Trouble *falling* or *staying asleep*?	○	○	○	○	○
14.	Feeling *irritable* or having *angry outbursts*?	○	○	○	○	○
15.	Having *difficulty concentrating*?	○	○	○	○	○
16.	Being *'superalert'* or watchful or on guard?	○	○	○	○	○
17.	Feeling *jumpy* or easily startled?	○	○	○	○	○

ANNEX C

AUDIT—INTERVIEW VERSION

The AUDIT: Interview Version

Read questions as written. Record answers carefully. Begin the AUDIT by saying Now I am going to ask you some questions about your use of alcoholic beverages during this year. Explain what is meant by standard drinks and how to calculate them. Code answers in terms of standard drinks. Place the correct answer number in the box at the right.

1. How often do you have a drink containing alcohol?
(0) Never (Skip to Qs 9-10)
(1) Monthly or less
(2) 2 to 4 times a month
(3) 2 to 3 times a week
(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2
(1) 3 or 4
(2) 5 or 6
(3) 7, 8 or 9
(4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

Skip to question 9 and 10 if total score for questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never
(1) Less than monthly
(2) Monthly
(3) Weekly
(4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
(0) No
(2) Yes, but not in the last year
(4) Yes, during the last year

Record total of items 1 to 10 here ➡

11. Do you think you presently have a problem with drinking?
(a) No
(b) Probably not
(c) Unsure
(d) Possibly
(e) Definitely

12. In the next 3 months, how difficult would you find it to cut down or stop drinking?
(a) Very easy
(b) Fairly easy
(c) Neither difficult nor easy
(d) Fairly difficult
(e) Very difficult

Do not score questions 11 and 12. These questions provide an indication of the client s readiness to change or motivation to change their alcohol use. This will assist you in deciding the level of intervention.