

Strategic reform of deployable mental health support

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Abstract

In this paper the mechanisms for deployment of mental health support (MHS) services are considered with reference to ADF Strategic Reform principles. The author suggests a more cost effective means to develop and deliver deployable MHS. He argues that MHS teams should be augmented by recruiting new health personnel categories such as medical and nursing officers with special training and experience. By using such a strategy, surge requirements would be met.

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Introduction

i. The Challenge.

Mental health reform in the ADF is gaining momentum due to a government requirement for ADF wide reform, a recent independent review, and the continuing efforts of health personnel in all services. Enabling factors include leadership from Joint Health Command through the tri-service Directorate of Mental Health, now known as the Directorate of Mental Health, Psychology and Rehabilitation (DMHPR); and ADF support for the recent Dunt Review recommendations and the allocation of \$83 million in the 2009 Defence White Paper to further reform and enhance the ADF mental health strategy(1).

The mental health reform agenda can be seen as part of a much larger program of strategic reform intended to improve ADF capability and efficiency through to 2030. (2) Defence personnel management is a primary target of this reform (pp 107-108). One of the personnel management reform requirements is to review of the ADF workforce mix across all functions and workplaces, in line with the total force concept, to identify where part-time uniformed (Reserve), Australian Public Service (APS), and ADF contractors, can be better utilised in preference to higher cost full-time uniformed elements.(3)

Joint Health Command, through DMHPR, is currently implementing the Dunt Review recommendations which require a greater investment in and ongoing enhancements and reforms to ADF Mental Health Services and to the ADF Mental Health Strategy as a whole.(4) At present, these reforms are focussed on garrison-based services within Australia(1), and it may be some time before the role of part-time uniformed elements, or APS civilian elements, are comprehensively reconsidered, particularly with respect to how they can contribute to deployable mental health support capabilities. It is that second stage of planning that the author wishes to address.

ii The Problem. There are several inconsistencies between ADF personnel reform principles and the current organisation of deployable MHS teams, namely:

1. The majority of deployable MHS assets are Army
2. The MHS teams are dominated by psychologists to the exclusion of ADF nurses, medical officers, psychiatrists, chaplains and APS civilian staff despite these other employment categories having often extensive and applicable MHS training and experience.
3. Scant attention is currently given to choosing staff most suited to the particular battle space viz. land, sea, air.
4. Surge plans in time of increased demand are inadequate (to the author's knowledge). This could mean that force preservation will be interrupted once initial MHS teams need to be relieved.
5. Military MHS is fragmented and training is inconsistent.

One way to begin addressing these limitations is to reassess the current system and consider how personnel elements can

be more optimally utilised in all battle spaces (land, maritime, air and space), involving all three services and all personnel categories, namely full-time uniformed, part-time uniformed, and full-time and part-time APS civilians.

This paper explores some of these limitations and how existing ADF mental health personnel might be reorganised and trained into deployable capabilities in line with current strategic and budget reform principles(3). Although there may be implications for how other ADF garrison health, rehabilitation and psychology services are organised, garrison services are not addressed. The author's aim is to identify, candidate organisational structures under both Joint Health Command (JHC) and Joint Operations Command (JOC) which can best develop and maintain mental health support capabilities to all operational environments. The main strategic reform principle applied is that the capability be developed as efficiently and cost effectively as possible. This would exclude expensive solutions such as employing additional full-time mental health professionals, altering existing categories of service, or adjusting existing conditions of employment. A key question is: Can a more cost effective way be found to organise, raise, train, sustain, and deploy ADF mental health personnel to operations (military and humanitarian) using well defined mental health support capabilities?

The need to reform deployable mental health support

i Staffing. A central theme emerging from the Dunt Review(4) and the White Paper(2) is the need to preserve military capability by increasing the readiness of ADF health personnel to operate in environments in which many seriously wounded casualties and many acute psychological casualties can be expected. The ADF continues to support the development of defined and deployable mental health support capabilities for the purpose of preserving military capability. One of these capabilities is now well developed and is known as critical incident mental health support (CIMHS). A recently revised Defence Instruction (DI) (5) summarises the evidence-based framework utilised for designing this capability. Pre-deployment training is provided to health personnel from several disciplines who can be deployed individually or in teams in response to commanders' requests for support for specific critical incidents or potentially traumatic events. This defence instruction details how this capability was developed and how it shall be delivered. But no statements are made regarding cost efficiency, or what composition of health providers should be selected for specific battle space tasks. This means that the potential benefits of service specialisation, and the use of more cost effective personnel elements are not currently considered. This issue is relevant to the reform of personnel management in the ADF, because there is an opportunity to plan and identify in advance, the most optimal mix of mental health personnel elements that can be prepared for short deployments. The advent of the SRP means inter alia that the most cost-effectively trained and prepared personnel are selected for short notice deployments into Land Command, Navy (maritime) or Air Force controlled environments. A tri-Service approach to the composition of MHS teams needs to be entertained.

The CIMHS defence instruction governs responses to critical incidents. But these are only one of several possible forms of mental health support: In episodes of mass casualties

high incidences of acute mental disorders can be expected. Supplementary strategies to manage such psychological morbidity could include: (1) in-theatre force preparation to minimise psychological injury during specific high risk tasks; (2) a psychological triage capability to minimise non-essential evacuations; and (3) immediate and proximal clinical treatments to reduce acute psychological distress and preserve the short-term functioning of key personnel. Factoring such plans into MHS would improve ADF force preservation.

Mental health support capability development

Table 1 shows the mental health support services currently developed into deployable capabilities and some yet to be developed. To date, two forms of mental health support to operations have been fully developed into defined capabilities supported by pre-requisite training. These are Critical Incident Mental Health Support (CIMHS) and Return to Australia Psychological Screening (RtAPS).

This table suggests a need for several other types of mental health support to both prevent and manage high rates of psychological casualties. A good preventative example is the promising new battle resilience training intervention, known as 'Battlesmart', currently being trialled by Army(6) with the intention of wider application in the ADF. There is also an urgent need to develop psychological casualty triage, and to develop in-theatre clinical interventions to counter acute individual stress as a means of preserving military capability.

Not to develop such strategies would mean continuing deployments of mental health qualified personnel to operations, or to units participating in operations, in the hope that these personnel will respond appropriately to the particular challenges and situations encountered. For instance Army, but not Navy or Air Force to the author's knowledge, have allocated Psychology positions to specific deployed units (e.g. Aviation, SAS), and routinely deploy full-time uniformed psychologists to operations. Navy and Air Force have deployed Psychiatrists, Medical, Nursing, and Psychology Officers with specific fleet units or on specific operations. These deployments typically involve officers with varying levels of mental health training. If the current situation prevails, the quality of mental health support services provided is likely to remain patchy and dependent on individual training and experience. The better alternative is to introduce common training which is evidence-based.

Demand for deployable mental health support

Provision of MHS ought to be demand driven, not supply driven, and provided via well-trained MHS teams that have demonstrated value in force preservation. Future demand for operational mental health support is likely to be influenced by the following factors: (1) the prevalence of both diagnosed and undiagnosed mental disorders in the ADF(7), particularly among deployed personnel or those eligible for deployment; (2) the adequacy with which ADF personnel are psychologically prepared for specific high risk tasks and operations, (3) the cumulative effect of exposure to previous high risk operations(7); and (4) recent casualty rates, current danger levels, and the current frequency of combat and expected incidence of potentially traumatic events.

Table 1. Defined mental health support capabilities.

Type of mental health service	Defined and deployable capability		Non deployed mental health service
	Maritime	Land	Garrison
Preventative	1. Wellbeing and resilience training (partly defined) 2. Resilience training for particular high risk tasks	1. Wellbeing and resilience training (partly defined) 2. Resilience training for particular high risk tasks	1. Wellbeing and resilience training; 2. Suicide awareness and prevention; 3. Alcohol, tobacco and other drugs program.
Early detection	Return to Australia Psychological Screening (RtAPS)	Return to Australia Psychological Screening (RtAPS)	Post Operational Psychological Screening (POPS)
Critical incident or potentially traumatic events	Critical Incident Mental Health Support (CIMHS)	Critical Incident Mental Health Support (CIMHS)	Critical Incident Mental Health Support (CIMHS)
Human factors and performance (e.g. fatigue management)	nd	nd	nd
Acute psychological casualty triage	nd	nd	Available via regional health services
Clinical treatment for acute distress (proximal and immediate)	nd	nd	Available via regional health services
Rehabilitation	na	na	Available via regional health and rehabilitation services

Notes: nd: specific capability not yet defined; na: not applicable to operations.

Mental health support services range from prevention through to detection and treatment, and long-term management. Although not all of these services may be required for deployment, each warrants consideration during operational planning. Mental health services that can support operations are broadly classified in Table 1. Alternatively, mental health support can be seen as part of a broader range of psychological support to the ADF that involves the support functions currently provided by garrison psychology and garrison mental health services. Murphy and Cohn(8) outline a three pillar support model that differentiates (1) organisational health and effectiveness; and (2) performance enhancement; from (3) psychological health and readiness, at an individual level. Mental health support to individuals is usually included within the last category. Because mental health support is construed as psychological support, there is the risk that other relevant support disciplines (medical, psychiatry, mental health nursing, ADF civilians) will be excluded. These supplementary supports will be needed in response to extreme events where psychiatric and psychological casualties may reach 30% or more of the deployed force. Outside the military, multidisciplinary teams are already the standard for the delivery of public funded mental health services(9). Within the military, health support planning can be enhanced by developing cost-conscious support plans with full anticipation of surge scenarios that utilise all appropriately trained health personnel.

ADF mental health personnel

What mental health personnel resources are currently available for deployment? It appears that full-time uniformed assets are often the first and only personnel deployed by both Joint Operations Command and Joint Health Command in both joint and single service operations. Even though other lower cost, personnel elements may be available at short notice. Land Command has a deployable full-time psychology asset (1 Psychology Unit), primarily geared to deploy Army Psychologists to Land Command areas of operations. This unit

has approximately 10 full-time Army Psychologist positions (Officers) and 9 full-time Army Psychology Examiners [Personal communication with DMHPR staff] and typically deploys these personnel for short periods to land based operations. These teams may be supplemented by part-time uniformed elements namely, Army Reserve Psychology Officers, Army Reserve Chaplains, and Army Reserve Psychology Examiners.

Navy has a deployable mental health unit intended specifically for the maritime environment. The Navy Reserve Psychology (NRP) branch currently consists of approximately 19 Active Reserve and 15 Standby Navy Psychology officers [Personal communication with Assistant Director-NRP]. In addition, one senior Active Reserve Nursing Officer with extensive civilian training and experience in public mental health nursing is routinely utilised for deployments with this unit.

However, maintaining deployment readiness of sufficient personnel to respond to all requests for assistance has been challenging because of inadequate specialised training, travel resources or unit administration support. NRP receive administration support from Navy Health but unlike 1 Psych Unit, they are a part-time uniformed unit with no home base, no full-time positions, no equivalent positions to Army Psychology Examiners, and no administration support positions other than the Assistant Director, who provides a range of administration and management roles.

The last review of the NRP branch identified deployment to maritime operations as a core NRP function(10)⁰. While this review was accepted, no subsequent action was taken by Navy to formalise its recommendations. This prompted the NRP branch to set its own priorities among the various support requests from both garrison and operational sources. The unit currently responds to all Navy requests for CIMHS and RtAPS assistance, and rarely needs supplementation from other uniformed elements. Responses usually involve small teams of NRP personnel who deploy to sea during return passage from

operations. NRP also provide Navy with support for within garrison psychology case work services and Post Operational Psychological Screening (POPS).

Army have approximately 100 Army Reserve (ARES) Psychology Officers and 100 ARES Psychology Examiner positions. About 40% of these are thought to be filled by Active Reserves [Personal communication with DMHPR staff] many of whom have been trained in RtAPs, POPS and CIMHS. ARES personnel therefore represent a potentially large deployable asset and surge capacity when needed.

Other potentially suitable personnel include an unknown number of uniformed health personnel with specialist mental health training. Air Force has an indeterminate number of full-time uniformed Health Officers, and Specialist Reserve Health Officers, some with extensive mental health training. This includes nursing officers, psychologists and psychiatrists, who could when released and prepared, participate in delivering deployable mental health support capabilities. Navy also have uniformed Psychiatrists, Medical Officers and Nursing Officers with suitable MHS training and experience. All three services utilise contracted civilian Medical Officers and Navy and Airforce also employ civilian Psychologists. Other civilian allied health professionals, drug and alcohol counsellors, and social workers, are employed by the ADF, all with varying levels of mental health training. Some of these non-psychology personnel are highly trained in mental health assessments and treatments and could be released for mental health support deployments.

The design of personnel records however, does not yet permit the identification of all full-time, part-time, and APS civilian personnel with suitable psychology, psychiatry, or other mental health qualifications and training. Therefore the ADF may already have a much larger but unquantified supply of suitable personnel with mental health training, possibly from Psychiatry, Medical, Nursing and Psychology disciplines. Most of these other disciplines are not currently utilised in existing organisational structures.

Limitations of current organisations

Table 2 shows some of the limitations of current organisations. A common limitation is the failure to utilise all available mental health personnel in multidisciplinary teams (Psychiatrists, Psychologists, Medical and Nursing officers) that are now the standard for civilian public funded mental health treatment and care(9). Furthermore, the primary existing organisation

(1-Psych) that provides the bulk of deployed mental health support to Joint Health Command operates on a high cost model using mostly full-time uniformed personnel for short deployments. In addition, neither NRP nor 1-Psych are sufficiently prepared to operate in all three battle spaces, neither organisation has surge capacity plans in place to respond to worst case scenarios where high numbers of acute psychological casualties are expected in both Maritime and Land Command environments.

Alternative organisations

Alternative ways to organise the deployment of mental health support capabilities are shown within Table 3. All options utilise the range of mental health personnel available. Options 2 and 3 provide the same capability as Option 1, but by using a lower cost workforce mix, but which may require a redistribution of resources across the three services to develop and sustain. Option 3 has the potential to be the most cost-efficient by combining resources at one site, while retaining Land Command and Maritime specialisations. The volunteers needed could be recruited by advertising new deployment opportunities to known personnel groups, bypassing the need to upgrade personnel records prior to identifying suitable personnel.

Full-time uniformed personnel need not be sidelined by any reorganisation which transfers the primary responsibility for deployable mental health support to part-time and civilian personnel. There are other important garrison and operational mental health support requirements that are best suited to full-time uniformed elements. For instance, long deployments to mental health support positions within special operations units (e.g. Aviation, Clearance Divers, and SAS) require full-time uniformed personnel or part-time uniformed members on long rotations or continuous full-time service. In addition, full-time uniformed personnel are needed to develop and test capabilities and train and sustain sufficient part-time uniformed and civilian elements to maintain high standards and to enable cost effective delivery of defined capabilities. Furthermore, since leadership of deployed mental health support teams is best selected on the basis of individual preparation, skills, qualifications and experience, full-time uniformed personnel could ensure leadership gaps can be covered when necessary.

Potential savings

Savings are anticipated through a reduction in the total number of permanent full-time uniformed psychology and mental health personnel needed by the ADF. A smaller number

Table 2. Mental health support personnel in the ADF.

Unit or personnel source	Primary deployed environment	Dedicated administration, logistics, and training support	Core personnel	Current surge plan
ARA 1 Psychology Unit	Land	Yes	Full-time	No
Navy Reserve Psychology	Maritime	Partial through Navy Health	Part-time	No
Air Force Health Officers and Specialist Reserve Officers	Land (air bases)	Yes	Full-time and Part-time	No
Other uniformed mental health specialists	Both	No	Full-time and Part-time	No
Other Defence civilian full-time and part-time mental health specialists	Both (Voluntary only due to employment conditions)	No	APS civilian full-time and part-time	No

of such positions could be retained to coordinate the training and preparation of all other personnel elements. Full-time ADF civilians represent a moderate saving of 20% or more, over equivalent rank full-time uniformed personnel. However, ADF Reserves represent a greater cost-benefit at a five to ten-fold saving, depending on how training and coordination costs are managed. This is because 15 ADF Reserve personnel serving 20 or more days each, can provide the same annual service coverage (48 weeks) as one full-time uniformed member, at nearly the same cost.

The savings mostly come from retaining fewer full-time personnel for mental health support contingencies. One full-time member could be used to train and prepare up to 20 part-time personnel, to provide a simultaneous deployable capability of 20 personnel for 4 weeks duration, which equates to the ongoing costs of only two full-time personnel. Under the current system, the 20 personnel deployed would most likely be full-time, sometimes supplemented by part-time members. This is about ten times the cost of dedicating this role to part-time personnel elements.

Part time MHS staff could be trained and organised, in a cost-conscious manner, as first responders for pre-defined

deployable health support capabilities. Since many personnel from several disciplines are already available to do this work, such a system could be established with savings generated through natural attrition of full-time uniformed personnel. In times of low demand for deployed support, a base unit could be tasked to develop new capabilities and develop surge plans for extreme events. Candidates from other disciplines with sufficient background mental health training would be attracted to MHS teams which provided sound evidence-based training and this would improve the opportunities to raise, train and sustain multidisciplinary MHS teams across the ADF.

Counter arguments

Some stakeholders will favour the status quo and will resist change, no matter what potential benefits could accrue in terms of improved health support capability. The aim of this paper has not been to advance a particular alternative model, but to bring the organisation of deployable mental health support capabilities to the reform agenda. How can these capabilities be best organised in the ADF? Whilst it currently makes sense to give deployment priority to the best prepared personnel elements (currently full-time uniformed Army Psychology), it is not logical to avoid planning for a surge capacity, or to ignore

Table 3. Alternative ways to organise deployable mental health support.

Organisation option	Advantages	Disadvantages
Option 1. Set lead agency as 1 Psych Unit, supplemented by a surge plan involving other part-time and full-time volunteer s (ARES, NRP, Reserve Psychiatrists, Health Officers, Medical and Nursing officers, and Defence civilians)	1. Strengthens an existing deployable unit with existing infrastructure and resources. 2. Over time, maritime and Air Force sub-units could be developed. 3. Utilises all available mental health trained personnel.	1. The focus remains on Land Command deployments by full-time uniformed personnel. 2. Personnel receive little or no training for maritime deployments and may become inoperative at sea through accidents or sea sickness. 3. The high cost is inconsistent with strategic and budget reform principles. 4. The short-term nature of typical deployments indicates suitability for part-time personnel. 5. Command and control remains unclear in Maritime environments.
Option 2. Establish NRP as the lead agency for maritime deployments. Retain 1 Psych Unit as the lead agency for all Land Command and Air Force deployments. Supplement both units with all other mental health personnel on a voluntary basis.	1. Solves the problem of competition between Land Command, Air Force and Maritime for the same mental health support resources. 2. Command and control in Maritime and Land Command environments is unambiguous, and service specialisations are retained.	1. Replicates an existing unit without identifying budget savings. 2. Does not address the reform goal of transferring deployment capabilities from costly full-time elements to part-time personnel elements. 3. New resources would be required for part-time personnel to maintain similar standards to full-time personnel.
Option 3. Create a new tri-service organisation (e.g. 1 Mental Health Support Unit). Develop two specialised divisions: (a) Land Command and Air Force; and (b) Maritime. Transfer both capabilities to part-time elements (ARES and NRP as core agencies) supplemented by full-time posted positions and positions for other volunteers, both full-time uniformed and civilian.	1. Solves the problem of competition between Land Command, Air Force and Maritime for the same mental health support resources. 2. Command and control in Maritime and Land Command environments is unambiguous. 3. Greater efficiency in the provision of infrastructure and training resources to both units. 4. Costs could be shared among the three services or met by JHC or JOC. 5. When not deployed or training for deployment, volunteers could continue to support garrison mental health services, and deliver preventative mental health support services and capabilities. 6. Savings generated through a reduction of 50% or more in full-time uniformed positions.	1. A redistribution of resources may be required to enable the new part-time units, supported by full-time personnel (uniformed and non-uniformed) to develop and maintain similar standards to full-time uniformed personnel.

more cost-effective utilisation of personnel elements, particularly when most mental health support deployments are typically of short duration, and the effectiveness of multidisciplinary teams is so well accepted in modern civilian practice.

Conclusions

This paper illustrates some examples of how strategic reform principles can be applied to the development of ADF mental health support capabilities. 1-Psych unit currently have the garrison location and the resources necessary to provide this range of services in a sustainable way, but at high cost and with no known surge capacity plan. NRP on the other hand have demonstrated how short duration mental health support can be provided as a core capability of a Reserve element, on a frugal budget with little direct involvement of full-time uniformed personnel. Neither unit currently makes best and cost effective use of all the available ADF mental health trained personnel.

A way forward is suggested by considering the three options shown in Table 3. Each represents increasing change consistent with Strategic and budget Reform. Although Option 3 represents the most change, it also promises the most cost effective base for the development of genuine tri-service and standardised mental health support capabilities. However these deployable mental health assets are organised, it will be important to give each a strong multidisciplinary focus to ensure the best mental health services are applied to force preservation when encountering high incidence of acute psychological casualties. JOC and JHC should be encouraged to further investigate the cost-benefits of a reformed organisation for deploying mental health services as outlined in Table 3. By doing so they

will comply with the requirement for ongoing cost-conscious strategic reform of health services in the ADF.

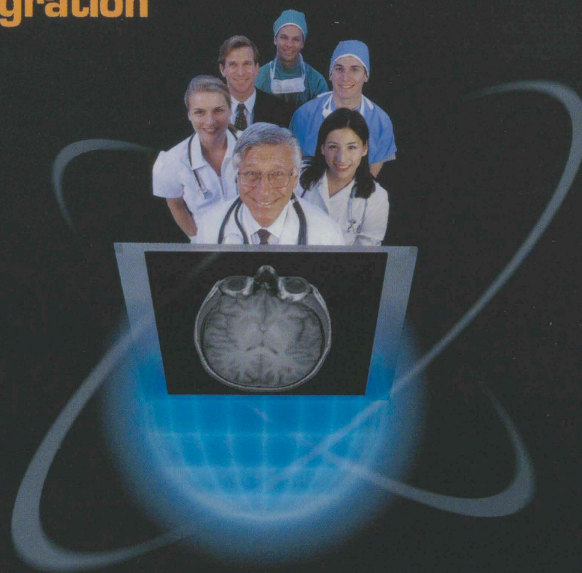
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