GRACE GROOM ORATION

Mental Health Australia

Vice Admiral Ray Griggs, Vice Chief of Defence Force

9 OCTOBER 2014

Thank you Chris for your introduction. The Chair of Mental Health Australia, Ms Jennifer Westacott, CEO Frank Quinlan, other distinguished guests ladies and gentlemen, good evening.

Can I start tonight by acknowledging the traditional owners of the land upon which we meet and pay my respects to their elders both past and present, can I also acknowledge all indigenous Australians present here tonight.

It's a pleasure to be here tonight and I am grateful to be asked to present this oration tonight. It's always both an honour and a heavy responsibility to give an oration named after someone of significance and in this case of course named after Grace Groom. Whenever I do this I try to adopt the style of the person who is being honoured.

The one thing I probably won't try and replicate tonight is Grace's renowned sense of humour but I hope in my own way I can honour her by talking about the mental health challenges that we face in the Australian Defence Force in a frank, honest and adult way; the way that she approached the mental health debate when she was alive. My view is that there is simply not enough adult conversation on mental health issues and from a Defence perspective there is a perception that there are those who lie in wait trying to catch us out on this emotive but incredibly important issue – the unfortunate by product of that is a lower risk appetite to openly discuss more difficult issues – that helps no one, least of all our people.

I am not, as you are aware, a mental health practitioner nor a mental health professional but I have over the last 35 years seen example after example of extraordinary young men and women deal with the challenges that their military service to this country imposes on them. I have had to deal with these challenges too in my own service as I know the other senior leaders of the ADF have.

I have witnessed the transformation of the organisation's response on mental health issues, I have seen the growing understanding of the causes, the need to screen, the importance of early intervention, the need to de-stigmatise and the need to support those who need help while in service and when it's required, to transition as smoothly as possible to the support services available once a person's service concludes.

I believe we have come a long way but we are by no means perfect and for every good story I can tell, someone will have a story that will make me wince or worse, despair. What I do know though is that there has never been a time, in the history of the ADF, when so much energy and so many resources have gone into improving the mental health and welfare of our people.

Now that little summary will no doubt not sit well with the mainstream world view of Defence and how it handles mental health issues. I would say that the broader public perception is one of a department that is slow, cumbersome, bureaucratic bordering on heartless and certainly not operating at the cutting edge of mental health practice. As I have declared already I certainly don't subscribe to this view and hopefully by the end of tonight you may have a different view too.

What I want to do tonight is talk about the ADF's military occupational environment through a mental health lens, talk about who are we, what do we do then hopefully bust a couple of myths about mental health and military service while talking about some of the many positive things that we are doing.

So, let me tell you about the ADF.

We are an organisation of around 58,000 full time and 24,000 part time men and women who wear our uniform supported by around 19,000 public servants. Today around 2240 uniformed personnel are deployed around the globe on 14 operations ranging from combat operations, to peacekeeping and border security.

Our primary role is to defend Australia and its interests, wherever they are engaged. Our span of tasks is incredibly broad, ultimately though what we must prepare for and regrettably execute all too often is the application of deadly force in a disciplined and controlled way; this is often done by quite young and junior people.

While it is not that fashionable to use the term 'warriors' at present, it is what we are and importantly what Australians expect and need us to be. There are those who have tried to de-emphasise and even discourage the use of the term and some have not unreasonably laid some of our cultural problems at the feet of the warrior ethos. But, to try and pretend we are something else is, in my mind at least, a view that imperils the core of our being.

The problem with 'warrior' is the traditional baggage that the term brings, particularly the tough male stereotype that it evokes which is problematic when viewed through from a mental health perspective. What is happening now is the modernization of what warrior means for today's ADF. There is quite a bit of nonsense about the changing nature of warfare; the nature of war is enduring, it has and always will be conducted to achieve political ends, it is brutal, it is violent and it involves placing men and women into extraordinarily difficult situations. We cannot fight and win as a defence force unless our people can deal with these realities; you only have to look at the ruthlessness of the enemy in Iraq to understand why that needs to be.

In the past, I suspect the organisation has at times focused primarily on getting the serviceman or woman through the operational moment or deployment and it has been less focused on what might happen to our people after the event. Our own national warrior mythology and the inherent toughness that it is built on, plays its part in this and complicates how we viewed mental health issues. This is despite the now undeniable fact that hundreds of thousands of returned servicemen over the last century were in fact suffering mental health issues but sadly lived in a time when suffering in silence was the norm.

Combat is the most brutal and violent expression of what we do and while its nature is unchanging, its character is. Close combat in a land setting has for so long defined the public perception of our war fighting, but combat at longer range in the air, at sea or behind a computer console such as our Heron Unmanned Aerial Vehicle crews in Afghanistan is no less brutal. The effects on our people operating 'at distance' are more subtle but potentially no less damaging and we must be alert to this as well.

Actual combat of course occupies a relatively small amount of our operational time, in a wide range of operations where the likelihood of direct combat action may be lower for an individual, its threat plays constantly on the minds of our people. Working in a workshop or warehouse environment in Kandahar in Afghanistan in a vital combat support role may be less dangerous than those operating 'outside the wire' but they both share the constant threat of rocket attacks for example. I recall during one of my visits to Afghanistan being shown the accommodation that I was to have stayed in that night, I say was to, because a rocket had hit the room the night before, I happily slept across the hall as I have always been a great believer in the lightning doesn't strike twice theory. The point is though that no particular aspect of operational service has primacy here, everyone in theatre is exposed to dangers, stressors and potential triggers.

It is no less the case in non-warlike operations where exposure to civil strife, the devastation of disasters and the human misery that accompanies them, or the challenges of border protection operations all play into the mental health landscape that we have to deal with.

It presents senior leaders with a challenging set of circumstances to prepare our people for and for us organizationally to manage and respond to. While we can train people to function in these circumstances we can never predict what will happen next.

One thing we can do though is to get our cultural settings right, I think in the past we have used very much the wrong terminology in describing the attributes and traits we need in our people, this has reinforced the long standing stigmatisation of both physical and mental health issues. We have picked up on particular aspects of the warrior mythology in saying we need physically and mentally tough people to do the job, for me that is the wrong approach.

We certainly need people to be able to meet the physical demands of our work, that goes without saying, we need people to exhibit both physical and moral courage and we need to ensure that our people are prepared for and as resilient as possible as they deal with the demands of the job. We need them to be ruthless and in the same breath compassionate, we need them to be able to operate as our patrols in Afghanistan or our ship's boarding parties in the Persian Gulf did, unsure of what would happen next and to do this day after day. Above all we need them to be anchored and driven by an intrinsic belief in our values and to be able to draw on them when they need to. So the simple notion of toughness as a concept works at one level, but from a mental health perspective in particular it sends all the wrong messages when people feel they are not measuring up.

From a psychological perspective we aim to train our people from when they first enter the force through to operations in a way that builds resilience, a term that in itself should be used with some caution. Training that reinforces the importance of team cohesion, that shows our people in a controlled way the things they are capable of and importantly using our values as a basis to inspire them to achieve things they never thought possible.

Our track record in that training has not always been good from a holistic perspective, we have always turned out effective warriors who can deal with the moment but have we properly prepared them for what comes next?

For decades we, and society more generally, simply did not realize the true impact of war on our people, on their families and all too often on those who were under their care. There was no real recognition of the struggles that individuals were wrestling with; many of course retreated into themselves. This has left us with a difficult organizational legacy and some aspects of our culture that we have been consistently working at changing.

We have transformed our initial training establishments from places where toughness was prized and abuse sadly tolerated to much more sophisticated and contemporary institutions where the importance of mental wellbeing competes equally with the professional outcomes we seek. Something we have also transformed is our approach to preparing our people for operational deployments. When people are identified for deployment they now undergo a range of mental health training that is specific to the deployed environment. This includes psychology briefs and the pre-deployment version of BattleSMART which is Self Management and Resilience Training.

BattleSMART is a preventive program which aims to enhance individuals' strategies for coping with increased stress and potential adversity.

It is underpinned by scientific principles and taught in four central domains:

- understanding likely physiological responses;
- adaptive ways of thinking about the stressful situation;
- adaptive behaviours; and
- emotion management.

This program can be delivered across a member's career - the basic concepts are the same, with content and delivery adjusted appropriate to career stage or operational circumstances.

It is not designed to prevent the development of trauma-related mental disorders but to assist in giving people an understanding of what to expect and tools to help them manage the situation.

BattleSMART is one of a suite of programs – LifeSMART targets ADF personnel transitioning to civilian live and FamilySMART is a resilience awareness package that has been developed for families and covers topics such as preparation for the member's return and what to expect, common concerns/challenges for families and members, and support options.

So given this backdrop and our focus on preparing our people throughout their training, what are our broader organisational priorities?

First, is to ensure we harness the undeniable power of strong and positive leadership in relation to mental health. In the military good leadership lies at the heart of every effective unit and every successful campaign and it is no different in relation to mental health. With strong leadership on this at all levels we will get better outcomes. What interests my boss should fascinate me is a maxim I have always found useful! It applies here too. That interest has to start at the top.

Understanding the potential exposure of our workforce demographic in relation to mental health issues is another priority. As Jennifer Westacott pointed out in last year's oration, around 50% of people who go on to develop ongoing mental health issues first exhibit symptoms before the age of 14. In broad terms then, around half of our people who develop mental health issues in the ADF entered our workforce with either symptoms or a pre-disposition. This puts an onus on our recruitment system to ensure that we get the balance right in assessing an individual's suitability to serve so that we don't recruit people who are high risk and then place them in untenable positions for which they may simply not be equipped.

An enduring priority for us is to convince our workforce of the importance of the de-stigmatisation of mental health within the ADF. I think we have done some good work here but, as you all know too well, this is a deep-seated issue not just in the ADF but across society

more generally that needs relentless attention. Our annual mental health day is one of our initiatives to bring discussion regarding mental health into the mainstream. In combination with our initial training programs and mandatory annual awareness training we try to keep discussion of mental health as part of our mainstream health dialogue. The theme for this year's mental health day is 'staying connected' which underscores the need for that dialogue and recognises the positive impact of maintaining connections with family, friends, work colleagues and community no matter where the individual is serving.

But one of the most innovative programs we have run which I think has helped not only the individuals involved but also the de-stigmatisation campaign more generally was the ADF Theatre Project. I am not sure how many of you saw 'The Long Way Home' which was produced in conjunction with the Sydney Theatre Company and played around the country earlier this year. It was a remarkable production with a cast of a small number of professional actors and a group of ADF members suffering from PTSD and physical injuries. It was truly inspiring to see these men and women sharing their experience through the power of theatre.

There were ups and downs over the six months or so that they were involved in the project, for many it was cathartic for others it was a battle – most moved forward but not all. But beyond the individual benefit there were three things that stood out for me. One was the organisational commitment to support the initiative and what it says about the ADFs approach, the second was the extraordinary passion and drive showed by the then Chief of Defence Force, General David Hurley to bring this project to fruition. But of greater importance from my perspective was that the message of PTSD was taken to tens of thousands of Australians in such a powerful and genuine way, a way that I think has played its part in reducing the stigma associated with mental health and PTSD in particular.

Another priority has been to develop a contemporary drug and alcohol management strategy. I think it's fair to say our traditional interest in drug and alcohol programs has been well and truly focused on either the organisational reputational issues that result or the physical health impact. I am not convinced that the linkage to mental health issues was at the forefront of our thinking in the past.

We all know the role that alcohol plays in our society and of its destructive impacts. In the ADF it has been amplified because of the nature of our work and the inherent pressures in what we do. But, there has been real change across the force in terms of:

- availability of alcohol,
- providing recreational options not focused around alcohol,
- a suite of counselling and treatment options, and
- an aggressive random breath testing program which in Navy in particular has seen significant and sustained reductions in positive test results and brought with it some very positive cultural changes.

Our focus on alcohol in particular has also driven involvement in related programs such as Life Education's Ocsober campaign which raises funds for drug and alcohol awareness education for our kids through people abstaining from alcohol for the month of October.

As Chief of Navy I pushed this hard as part of Navy's broader approach to adopting a healthier lifestyle. In fact, if you want to stop tweeting for a minute and would like to go to the Ocsober website and sponsor me for this year's campaign I would certainly appreciate that!, While the fundraising is important the increasing levels of participation across the Navy is more so.

Our approach to illicit drugs is very clear and strong, some would say hard line – again an aggressive testing program has also seen significant reductions and importantly there is a wide spread view amongst our people that illicit drug use has no place in the ADF.

Given the nature of our work, effective mental health screening processes are essential. We have seen the benefits of this for the tens of thousands of ADF members who have deployed in operational theatres in recent years with the combination of the Return to Australia psychological Screen (RtAPS), which, as the name implies, is the screen just prior to or immediately after return from deployment and the follow up Post-Operational Psychological Screen (POPS). We have worked hard to achieve full compliance from our people in undergoing these important screens, this has taken strong leadership and it ensures that we build the best picture possible and can spot issues early.

In 2011 we introduced a modified annual mental health screening process for our people engaged in border protection operations. We have a good critical incident support process but we felt that in the aftermath of the awful explosion in SIEV 36, the tragic foundering of SIEV 221 on the rocks of Christmas Island and the frequent recovery of bodies during these operations that a formal screening process was required given that many of our patrol boat sailors in particular spend most of their careers working this mission. That process is now well entrenched and we have not seen any evidence of rates of PTSD that vary significantly from the broader ADF population.

But what has been lacking is a regular mental health screening process outside those who are screened when they deploy or following a critical incident. That is why we are working to fill in this last gap in our mental health screening continuum.

Our final priority is to ensure that the quality of the care we provide our people is as good as it can be. We have significantly increased the resources allocated to mental health in recent years – having spent $117 million on mental health services and nearly doubling the number of mental health professionals in Defence since July 2009.

In 2012 we established a dedicated ADF Centre for Mental Health at HMAS Penguin in Sydney, the Centre, since 2013, in conjunction with the Australian Centre for Post Traumatic Mental Health has been upskilling the ADF mental health workforce to more effectively assess and treat members with post-traumatic mental health problems and disorders.

As I alluded to earlier, our wide range of our operational activity generates many stressors and triggers and PTSD is an important issue for us. One of the myths we have regarding PTSD is that in the ADF it is heavily linked to combat situations like our activities in Afghanistan. But, we know from our research that this is simply not the case.

In 2010, we conducted the ADF Mental Health and Wellbeing Prevalence Study in partnership with independent academic research bodies.

We found that approximately one in five of our people (including those who had deployed and those who had never deployed) reported experiencing a mental health disorder in the previous 12 months – this covers the spectrum from anxiety to affective mood disorders, and includes PTSD. As Jennifer described last year, this is a similar rate to the Australian community.

More specifically, the research found that PTSD among ADF members was around 8.3 percent. While this is greater than the Australian community (5.2%), the study found that ADF

members who had never deployed were just as likely to have PTSD as those who had deployed.

We have found through this research that the majority of incidences are the result of accumulated trauma in their personal and or military lives rather than the direct effect of ongoing deployments or military service.

We are also alert to the potential impact of multiple deployments on mental health and rehabilitation needs. However, our research is consistent with international findings that the number of deployments is not as predictive as the level of trauma or combat exposure.

Another myth I am keen to dispel is that Defence is suffering what has been described as a tsunami of PTSD. Something David Hurley said when addressing concerns about this in 2013 - the 'tsunami' or 'tidal wave' analogy presents a view that we are powerless to stop the problem, that it is unexpected and we are helpless to the devastation it will bring. This is just not so and I agree with General Hurley about the inappropriateness of the analogy. Of course in trying to have an adult conversation on this issue we are accused of denying the existence of the problem.

Nothing could be further from the truth, we are well aware of what we're dealing with here. But, it is difficult to precisely forecast the future demands on health services or the long term PTSD profile that we will see from this prolonged period of high operational tempo. However, what we do know is that at least 10 per cent of ADF members may seek help in the short to medium term for mental health issues and we are prepared for this.

Another myth is that we have a suicide problem in the ADF that is out of control. Any loss of one of our people is a tragedy and a suicide is a particular one because the unanswered question will always be what more could have been done to help. Since January 2001, we have tragically lost 103 ADF members to suspected or confirmed suicide. Perhaps surprisingly, given our circumstances, this is slightly lower than the general community.

Around 60% of those who have died by suicide had not deployed on operations, which suggests that the widely held view that there is a strong association between suicide and deployments is not correct.

One thing we cannot do though is track suicide rates for those who have left the ADF and this is an issue of intense interest both to us and the veteran's community. The Department of Veteran's Affairs track prevalence of suicide in ex-service personnel who have used their services. DVA is taking the lead on a data linkage project with Defence, the Australian Institute of Health and Welfare and ComSuper to integrate data to determine the rate and cause of death in serving and ex-serving ADF members. This project is in the early stage of planning and will be an important addition to our knowledge base. We of course have, for many years, had a comprehensive suicide prevention program, which targets our mental health professionals as much as it does every member of the ADF on the signs to look for.

I was very pleased last year when Defence was awarded a National LiFE (Living is For Everyone) Award in the category of Public Sector innovation and commitment to the reduction of suicide. External recognition is always important for those working so hard in this crucial area.

A challenge we still have is how the command chain fits into the management of personnel with mental health issues. We have a deliberately non-descriptive medical categorisation system that will make it clear to the organisation how a person can or cannot be employed but not why. The Commanding Officer has a particular duty of care for all under his or her command and there have been times when interpretation of the Privacy Act in favour of the

individual has denied key elements of that person's mental health history to a Commanding Officer. This has presented significant challenges when command teams are managing emerging situations particularly in operational scenarios. While it is important to ensure the safety, rights and wellbeing of the individual this needs to be balanced against both the safety and effectiveness of an operational unit. My personal view is we still have work to do here to bring the pendulum back to where it should be.

In terms of transitioning those who cannot continue to serve on we have ADF Transition Centres to link our people to a variety of services and agencies, including DVA, ComSuper, Centrelink, Veterans and Veterans Families Counselling Service and other support services as required.

And finally, while we do work closely with DVA, we have also more recently been focused on enhancing how we work with ex-service and community-based organisations such as Soldier On, and Mates4Mates.

I think I have taken you on a fairly comprehensive wander through the ADF's mental health landscape. Our work is unique and the landscape is a complex one. We will never be able to mitigate the risks to a level where our people won't be exposed to stressors and triggers. But, I think as an organisation we have made significant ground in recent years - we still have much to do and we know it is an area we cannot take our eye off.

We ask much of our people across the very broad spectrum of our operations we undertake. Many of them are difficult and challenging and our predominantly young workforce I think does an exceptional job day in day out. They are not all saints and we have our challenges but I think you can all be exceptionally proud of what they do and the professional way they do it.

Our responsibility is to ensure we equip every individual as best we can for what lies ahead, to have strong, cohesive and inclusive teams that support each other and to actively screen, intervene, treat and care for them when they need it. In short we want to enhance resilience and enable recovery. Given what we ask of them, we certainly owe them that. It's been a pleasure to speak to you tonight on such an important issue. Thank You.