Mental health presents obvious extra challenges for armed forces, the ethos of which necessarily values physical and mental toughness as well as teamwork.

Prof David Dunt

Review of Mental Health Care in the ADF and Transition through Discharge

Since 2001, the ADF has increasingly focused on the diagnosis, treatment and mitigation of mental health issues associated with operational service. With the likelihood that ADF personnel will be exposed to challenging environments, combined with an increase in the reported number of mental health issues being suffered by ADF personnel, there is widespread appreciation of the enduring need for a whole-of-government response to mental health problems being experienced by ADF members.

The current ADF approach is in marked contrast to the policies and treatment of personnel in past conflicts. During World Wars I and II, ‘shell shock’ and ‘battle fatigue’ became commonplace terms to label a condition many veterans suffered as a result of active service. Poorly understood, and at times not widely accepted as a legitimate medical condition, there was a gradually growing appreciation that the experience of combat operations could have serious consequences to mental health. What was not fully appreciated was why some members might be more susceptible than others with similar experiences, the cumulative effects of repeated exposure to traumatic or stressful events and how time may not be a healer, but a period of incubation for more debilitating symptoms.

The case of Bomber Command during World War II, the limited understanding of mental health issues gave rise to what would be considered today as less-than-sympathetic policies and personnel management practices. The term ‘lack of moral fibre’ began to be applied to personnel who were unable to perform their duty to a standard expected by their chain of command. This problem was at times further exacerbated by the demands of war and an expectation that the threat to national security took precedence over all other considerations, especially the needs of the individual.

The experience of RAAF personnel serving in the RAF’s Bomber Command of the management of mental health problems was not atypical. The high casualty rates and long, stressful missions typical of bomber operations coupled to produce an intense environment likely to cause any number of mental health issues. While policies on how to treat and manage these members progressively developed during the war, there was not a sufficient appreciation within the medical community and among the commanders on the bases of the nature of mental health problems which might have ensured a more sympathetic approach to many members.

Hudson’s case also illustrated how administrative policy as well as medical practices must be aligned to ensure the interests of the service and the affected member are looked after.

Hudson initially joined the Australian Army in 1940 and served as a combat engineer with the 2/5th Field Company through the Western Desert and later the Kokoda Track campaigns. In 1943, Hudson transferred to the RAAF as aircrew and was trained as a navigator. As was typical of the period, Hudson was posted to the RAF as part of the Empire Air Training Scheme for service with a RAF squadron. On arrival in the United Kingdom,
he underwent operational conversion training on heavy bombers and was part of a crew almost at the point of being sent on operations over Germany in late 1944 when he reported problems to his commanding officer.

In essence, Hudson began suffering extreme anxiety each time he flew to the point he felt unable to function while in the air. As bomber crews only included one navigator, Hudson was certain he was placing the safety of his crewmates in jeopardy by his inability to control his anxiety and to function effectively. Initially, the response from Hudson’s chain of command was sympathetic and a course of medical treatment and rest was pursued. However after Hudson felt that it made no difference to his condition, he requested that he be removed from flying duties. It was at this point that the limited appreciation of mental health circa 1944 and the administrative policies of the time combined in a manner which resulted in Hudson being considered to be lacking moral fibre and he was discharged ‘service no longer required, with disciplinary effect’ in October 1945.

In light of Hudson’s service in North Africa and PNG, the manner of his discharge seems harsh. The origins of the policy which generated this outcome can be found in a 1942 Bomber Command study on the cumulative effects of the stress experienced on missions over Germany. The study found that some aircrew who experienced repeated stressful events while on operations were more prone to suffering extreme fatigue, difficulties in concentration, sleeplessness and anxiety. In response to the study and to manpower concerns, the Air Ministry issued Memorandum S.61141/S.7.c. This memorandum spelt out the RAF policy on dealing with aircrew suffering from stress related conditions and the actions to be taken in cases where there were no identifiable flying stressors involved.

The policy reflected an organisational belief that if left unchecked, the numbers of aircrew refusing to fly due to anxiety or stress would cripple Bomber Command’s war effort. To act as a deterrent, aircrew who were unable to demonstrate how events while on flying operations had had a cumulative effect on their health lost all rank, their flying brevet and were discharged for ‘lack of moral fibre’ or for ‘disciplinary effect’. The policy did not recognise that a member may have experienced extreme stress in other periods of service not flying related.

In Hudson’s case, notes on his file indicate that in one doctor’s view, it was ‘not a case of being afraid but the consequences of nervous strain’. The same doctor was also of the opinion that Hudson’s previous Army service contributed to his condition. However, as no flying-related stress could be identified, the administrative system could not comprehend any alternative but discharge under the harsh policy of the day.

The stigma felt by Hudson was unnecessary; he had served with honour but was forced out by a policy which, while well informed by the standards of the time, did not recognise there are many contributing factors to mental health problems which may not be immediate or obvious. The policy was too simplistic to balance the good of the service with the needs of the individual. To ensure that Air Force meets its responsibilities to its members and to project air power on current and future operations, it remains an imperative that the complex nature of mental health is understood and that support mechanisms are in place to aid personnel who suffer as a result of their service.

**Key Points**

- Mental health issues as a result of operational service are not new, but the means to identify and treat members has developed into a more meaningful capability.
- To remain relevant, air forces should evolve and change. This is not limited to how technology is employed, but the policies and practices of how its members are employed and supported.
- For more information regarding mental health in the ADF go to: http://dmnet.defence.gov.au/VCDF/ADFHealthWellbeing

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The tension and stress associated with combat operations does not stop at the completion of the mission, time does not heal all.

(Mission’s End, Michael Howard 1995, RAAF Heritage Collection)