

Military Mental Health: from shell-shock to PTSD and beyond ¹

Air Chief Marshal Mark Binskin, AC, Chief of the Defence Force

The topic is painful; perhaps one of the saddest of the many grievous aspects of the War. But a condition exists at present which is immeasurably more painful—the exaggerated and often unnecessary distress of mind in many of the sufferers and their friends, which arises from the manner in which we, as a nation, have been accustomed to regard even the mildest forms of mental abnormality.²

Those words, from Professor Grafton Smith and his colleague Tom Pear, capture Australia's long-held attitude toward mental health issues and the battle we face to remove the stigma associated with mental illness. What makes these words even more insightful is that they were written in 1917.

I begin with this quote because it highlights the very issue we face in addressing mental health in the ADF today. How do we break the nexus between seeking assistance for the psychological scars of military service and the perception that this is somehow a sign of weakness? The question is as relevant today as it was 100 years ago, when the first wounded Diggers of the Gallipoli campaign began to return to Australia.

For much of the past century, psychiatrists, psychologists and other mental health professionals have struggled to understand the complex consequences of military service on the human psyche. Everyone who goes to war is changed by the experience. Extreme fatigue and stress, combined with sustained attack or threat, can have a dramatic effect on a person's mental health and overall wellbeing.

These stressors are not just confined to land battles or even combat. They apply equally to air and maritime operations, as well as non-warlike operations where exposure to the devastating effects of natural disaster or human suffering can be equally onerous for military personnel. Historically, commanders have faced a dilemma—preserve manpower or preserve the man—and, in the current context, woman. That is the tension between the need to maintain a fighting force and the desire to look after an individual's welfare. It is a vexed question and one that at different times and under different circumstances will produce a different answer.

In the immediate thrust of battle and under attack, a unit's collective ability to fight off the enemy and defend itself will likely override any one individual's needs. But in a long game, the individual soldier, sailor, airman or woman's welfare must come first. This has not always been the case, particularly during the First World War when shell-shocked soldiers who succumbed to their psychological distress were branded as weak and cowardly.

World War 1 was characterised by trench warfare. Troops were continually subjected to shelling with little to no respite from the frontlines. The term 'shell-shock' was commonly used to describe soldiers who, having sustained concussion from the impact of a shell, were believed to have disrupted their brain. The shell-shocked soldier would emerge in a dazed and often disoriented state. Treatment was usually administered in casualty or clearing stations where soldiers were given a few days rest, frequently under sedation. The soldiers were fed and reassured that their reaction to the shelling was normal and that things would disappear after a few days.

This frontline care served the military objective to preserve manpower while also sending a clear message to the troops that shell-shock was not a fast track home. But perhaps most importantly, commanders, medical officers and medics recognised the importance of treating shell-shock as soon as possible after symptoms emerged. Left untended, the symptoms would become resistant to treatment. This theory became the precursor to what we know today as 'critical incident response'.

However, despite understanding the need for rapid treatment, the military viewed shell-shock as a disciplinary problem in that those who displayed symptoms simply lacked the willpower necessary to manage fear in battle. Some medical professionals doubted the condition's legitimacy and saw those who were suffering as malingerers.

By the time the first wounded ANZACs returned to Australia on the hospital ship *Kyarra* in July 1915, Australia was mourning the growing number of men killed at Gallipoli. The overwhelming number of Australians killed and wounded in action in the Dardanelles overshadowed the psychiatric damage endured by those who survived. Those who came home were considered the 'lucky ones'—lucky to survive the horror to return to their families. Sadly, behind the fanfare and the tickertape parades, those who were too distraught or disfigured were stretchered straight to hospital—hidden from the view of the potential candidates that recruiters were attempting to enlist.³

As Australian families continued to welcome home changed men, much of the veterans' practical and emotional care fell to mothers, wives or sisters who adopted a patriotic stoicism to care for them in their own homes. The shame metered out to shell-shocked soldiers on the battlefield followed them home. Veterans who returned with physical wounds were revered for their honourable sacrifice, while those who came home with mental scars were, at times, humiliated and scorned as failed ANZACs. Families who could not cope with the burden of caring for a shell-shocked veteran in the home turned to institutional care but, for many, this created a new quarrel as they fought for appropriate recognition and care.

In the years after World War 1, Australia felt an obligation to care for the nation's repatriated soldiers and a two-tier mental health system emerged—civilian lunatics who were locked away in asylums and segregated from mentally-ill veterans who were admitted to repatriation hospitals. Civilian asylums were overcrowded, and with insufficient staff or resources, patients were routinely sedated or restrained.

By contrast, military institutions provided a much higher standard of care with better quality food and staff, as well as day trips and other organised activities. Families desperately fought for the best possible care with the least stigma. To many, segregating veterans from the civilian population was seen as recognition that their soldiers were damaged, not insane.

Yet the government continued to take the view that those who suffered from shell-shock had some hereditary pre-disposition and, with a shortage of beds in military hospitals, that meant families had to build an argument to demonstrate to the Repatriation Department that the soldier's condition was a result of his service.⁴ This was, and remains, far more complex than for physical injuries. At the time, each state was responsible for institutional care which resulted in inconsistent assessments. For example, in 1927, Victoria had almost 1300 cases of war neurosis recorded while NSW documented less than 400.⁵

Toward the end of World War 1, Smith and Pear, the British doctor and academic quoted earlier, published a paper titled *Shell Shock and its Lessons*.⁶ They favoured the term 'war strain' over shell-shock, and defined the condition as 'those mental effects of war experience which are sufficient to incapacitate a man from the performance of his military duties'.⁷ They rightly, and insightfully, also wrote about the 'absolute necessity of obtaining and understanding the patient's past history before and during the war'.⁸

Smith and Pear agreed with the assessment of frontline doctors and medics who advocated the need for early treatment for war strain. The rationale for such an assessment will be all too familiar to many but particularly for those of us who have lost a colleague on operations or in training. Smith and Pear argued that left untreated, we will continue to play out the 'what if I ...' question inaccurately in our minds. This, combined with the natural human tendency to try to conceal our troubles beyond the family unit, can lead to a delay in seeking help as we try to battle on until the situation becomes intolerable.

This British duo was among a growing chorus calling for greater research, more education and better treatment for mental health issues arising as a result of military service, believing that 'the strongest man when exposed to sufficiently intense and frequent stimuli may become subject to mental derangement'.⁹ This view that *all* military personnel were vulnerable to battle fatigue also gained momentum in the US during World War 2, where the US Army adopted the official slogan 'Every man has his breaking point'.¹⁰

Despite an increased focus on weeding out the less resilient during the recruitment phase, the notion that we are all vulnerable means no matter how rigorous our selection processes, we can never completely

avert the risk of psychological injury as a result of exposure to traumatic events.¹¹ There was also a growing consensus throughout the medical profession that anyone exposed to trauma, even those with no previous history of mental health issues, was vulnerable to combat exhaustion. This marked the start of a fundamental shift in the way clinicians viewed military mental health. The focus switched from 'problems of the abnormal mind in normal times' to 'problems of the normal mind in abnormal times' to question why a soldier *did not* succumb to anxiety rather than why he did.¹² Unfortunately, the clinical progress did not automatically transfer to the military ranks.

Throughout the Second World War, mental health conditions remained highly stigmatised and those who broke down were still considered weak in the eyes of peers who saw the lack of mental strength as a lack of masculinity. During that period, the Royal Air Force introduced the term 'lack of moral fibre'. It was an administrative label rather than a medical or psychological term used to describe airmen accused of cowardice, who were unfairly deemed to be more concerned with their own survival than the cause. To put that in context, these men served in Bomber Command at a time when they took off for each mission knowing there was a 1 in 2 chance they would not return—yet the stigma attached to a perceived 'lack of moral fibre' was such that the fear of being branded a coward was more terrifying than enemy night-fighters.¹³

Back home in Australia, the two-tier mental health system that emerged in the shadow of the First World War continued to widen the gap between military and civilian care. However, mental health care became a casualty of the Great Depression and the financial burden of World War 2. Institutions fell into an appalling state of disrepair and patients who were subjected to substandard conditions lost all human dignity. Sadly, this only fuelled the stigma associated with mental health conditions and increased competition for beds in repatriation hospitals as families fought for the best possible care for veterans who returned with what was then known as 'combat exhaustion'.

As an unintended consequence, Australia owes many of its advances in mental health to the psychological casualties among those who returned from the First and Second World Wars and the increased demand for more effective care. The lessons learned from previous war-time experiences also informed a more strategic approach to counter the stressors and trauma as Australian troops entered Vietnam alongside the US. From the beginning, the US deployed trained psych officers with each battalion and, based on their World War 2 experience, soldiers were restricted to a 12-month tour with periods of rest and recreation scheduled into the deployment. Australia did the same. These preventative measures resulted in fewer reported incidences of combat stress during the conflict but the post-war experience told a very different story.

In the early years, Australians generally accepted our participation in the Vietnam War. However, by the early 70s, opposition grew with the rising number of conscripts being deployed and killed.¹⁴ The anti-war sentiment in Australia at the time meant our Vietnam veterans were predominantly reviled rather than celebrated as their forebears had been, returning to an often hostile reception from anti-Vietnam activists who spat at and abused the veterans, branding them baby-killers and murderers for simply doing what their country, and their Government, had asked of them.

Compounding their angst, as a community we had largely reverted back to World War 1 thinking, that is, that a veteran's mental health issues must arise from a pre-existing condition rather than originate as a result of any trauma experienced in service. This had a significant knock-on effect. The shame associated with mental health conditions increased dramatically and very little attention was directed toward post-war care. Consequently, the delayed onset of psychological trauma—which typically emerged from nine months to two-and-a-half years after a deployment—was largely ignored, leaving veterans and their families to battle the demons on their own. As a nation, we should be ashamed at how our Vietnam veterans were treated and the stigma they were forced to endure.

Following World War 1, shell-shocked veterans received the same pension status as those who returned with physical injuries. In order to claim a war pension after the Second World War, veterans with psychological wounds had to prove their condition was the result of war service and not a hereditary predisposition.¹⁵ Yet after all that we had learnt, Vietnam veterans had to wait until 1980 for acknowledgment that post-traumatic stress disorder (PTSD) was a legitimate mental illness, caused by the cumulative effects of exposure to the trauma and hardships of war.¹⁶

Australia failed our Vietnam veterans. We took too long to recognise the enduring effect the conflict had on those who were sent to fight. Officially, 521 Australian servicemen were killed and more than 3000 were wounded but a recent study provides a sobering insight into the true cost of the war. This study examined the pension entitlement records of every Australian who deployed to Vietnam—all 60,228 ground troops, Air Force and Navy personnel. Over a 43-year period, a sobering 47.9 per cent of those who served in Vietnam had an accepted claim for a mental health condition.¹⁷

For me, as the Chief of the Defence Force, that figure underscores the critical importance of ensuring we provide first-class mental health care for every person who serves under my command. I, the Vice Chief and the three Service Chiefs have a duty to provide the best possible mental health treatment and support programs available. We also have a responsibility to continue our research while implementing the lessons learned from previous conflicts and operations.

Vietnam triggered a new wave of studies into military mental health too numerous and too complex for me to adequately mention. I will instead focus on what the ADF has learned and implemented as a result of our wartime experience, as well as the challenges we face in caring for the current and future generations of veterans.

Unlike First and Second World War veterans who took a sea passage home, many of our personnel flew directly from Vietnam to Australia. Their struggle to reintegrate from the battlefield to the backyard taught us the value of 'decompression' immediately following deployment and prior to returning home. The horrific experience of the Australian Medical Support Force who witnessed the slaughter of thousands of people on the UN Assistance Mission in Rwanda reminded us of the potentially-damaging effects of peacekeeping and humanitarian missions. Our operations in Cambodia, Somalia and Bougainville during the 90s were the catalyst in 1998 to introduce standardised mental health screening for every person after every deployment, including humanitarian and disaster relief missions, or training incidents and later border protection operations. And our experiences in Iraq and Afghanistan are the driver behind our determination to more fully understand all factors that impact on the mental health of our people.

In the past six years, we have invested an additional \$146 million to enhance our mental health care programs and services. We have almost doubled the number of mental health positions in our workforce. Additionally, we have taken steps to strengthen our resilience training to help people cope better with the unique risks of military service, and we are leading the way with world-class research to help us understand the nature and rate of mental health conditions among our military population.

Our research clearly demonstrates that exposure to trauma increases a person's risk of developing a mental health disorder such as PTSD. For some, that traumatic exposure will occur on operations, while others may experience traumatic events outside a deployment. So deployment, while significant for some, is not necessarily the sole determinant for all. We also know that a mental health condition may result from a single incident or develop with cumulative exposure to multiple events over time and, regardless of its nature, the effects of such exposure may be immediate or may take years to manifest.

Importantly, as the evidence attests, the majority of ADF personnel will not develop PTSD. The 2010 *ADF Mental Health Prevalence and Wellbeing Study* showed that one in five (22%) of the ADF population had experienced a mental disorder in the previous 12 months, which was similar to the rate of the Australian community (20.7%).¹⁸ The same study found around 8.3 per cent of ADF personnel experienced PTSD (4169 of the ADF's population of 50,049 in 2010), with 50 per cent of those reporting having received treatment in the previous 12 months.

We are acutely aware that one of the major barriers preventing people from seeking treatment is the misbelief that a diagnosis of a mental health disorder such as PTSD will mean the end of their career in the ADF. Unfortunately, the problem is that the longer someone hides their symptoms and avoids treatment, the greater the risk for this to occur. We are gradually seeing examples where people who have undertaken rehabilitation are returning to work in the ADF. From July 2013 to June 2014, a total of 813 people undertook the ADF Rehabilitation Program after being diagnosed with a mental health condition, such as depression or anxiety disorders, including PTSD. Of those, 421, or 52 per cent, successfully returned to work in the ADF.

Yet the perception of weakness and shame associated with asking for help remains the greatest barrier preventing access to care and treatment for mental health issues—not just in the ADF but in the Australian community at large. Sadly, it is rare to see one of the many successful recovery stories in the media. Further, I believe ill-informed commentary that criticises our care, combined with a lack of knowledge or understanding of the support services available to our personnel, only adds to the stigma and sense of helplessness that further deters people from getting the essential help they need. Which brings me back to the century-old quote I began with, and the sad reality that too many in the ADF still shun treatment and suffer alone because of the stigma that we, as a nation, assign to even the mildest mental health condition—just as we did 100 years ago.

So where do we go from here to ensure we meet the challenges facing our contemporary veterans who may experience symptoms for decades to come?

Firstly, if the Vietnam War has taught us anything, it is that the health and wellbeing of our people is paramount and there is no place for politics or point scoring from anyone in dealing with military and veteran mental health. We must be responsive to the specific needs of our people and their families. We will help those under our command to build and maintain a level of resilience throughout their military career. We will ensure they are encouraged to seek help as early as possible, no matter what the cause of their mental health condition and when they do, we remain committed to providing them with the best evidence-based care and rehabilitation available that supports their recovery.

Fundamental to strengthening resilience and supporting recovery is accepting that the individual member, commanders and health care professionals have a shared responsibility for ensuring a person's health and wellbeing. Mental fitness is just as important to the ADF's capability as our physical fitness, and we need a holistic approach to address the issue. We cannot simply brand it as a health issue and rely on a clinical response. Understanding mental health is a critical part of our command and leadership training and a key consideration in our personnel management.

This is somewhat complicated by the *Privacy Act* which currently applies a uniform standard for service personnel and civilians in determining who has access to an individual's personal health information. While we proactively seek an ADF member's consent to release this information to family or commanders, any decision regarding the disclosure of a mental health condition rests with the individual. That said, there are still things commanders and colleagues can do. We have to learn to look out for each other, not just on the battlefield or on operations, but in our day-to-day interactions and our social circles. And we must continue to develop a family-sensitive approach to ensure they too are included in the mental health and rehabilitation services we offer to ADF personnel.

The current suite of evidence-based treatment, rehabilitation and awareness programs available to ADF members are among the best in the world. These are administered and provided by Joint Health Command as well as each of the Services. We are well aware there is no 'one size fits all' formula, which is why we employ multiple, targeted programs to develop a tailored recovery plan to suit each individual person and their family. The ADF 'Arts for Recovery' initiative, for example, uses music, drama, creative writing and visual arts to aid recovery.¹⁹ It follows the highly-successful ADF theatre project 'The Long Way Home' that exposed a whole new audience to the anguish of PTSD many of us experience as a result of the difficult and often dangerous work we do.²⁰

I believe there has never been a time, in the history of the ADF, when we have invested so much energy and so many resources into understanding and improving the mental health and welfare of our people. There is much we have learned that can benefit similar organisations such as the Australian Federal Police and the Australian Border Force. Additionally, it would be remiss of me not to acknowledge work undertaken by the Department of Veterans' Affairs (DVA) over many years and the lessons learnt from the needs of past veterans to better meet the emerging needs of our current serving members, veterans and their families.

Defence and DVA have worked hard in recent years to build a more collaborative relationship that is helping us to create a more integrated approach to supporting the care and transition of Defence personnel at the end of their military career. Of course, there is also the work being undertaken by traditional ex-service organisations and the new community-based welfare groups that are offering

innovative rehabilitation and psycho-social recovery programs that complement and enhance our own Defence-based treatment and rehabilitation programs.

All of this is not to say the job is done—far from it. There will always be more we can do and we should continue to strive for improvement. Further research, including longitudinal studies, are required to ensure we do not underestimate the risk or cost to our personnel, and we need to work collaboratively beyond the ADF to build a greater understanding of military mental health. Defence is currently working closely with DVA to examine and understand the impact of military service on the mental, physical and social health of current and ex-serving personnel who have deployed to contemporary conflicts.

To update our knowledge following on from the 2010 study, the ‘Transition and Wellbeing Research Program’ is part of a new shared-research agenda between the two departments, with approximately \$5 million being invested in the program over three years.²¹ It will also be profiling, for the first time, the impact of service on the mental health and wellbeing status of reservists as well as that of Defence families. By understanding the impact of military service, deployment experiences and the associated health outcomes of serving and ex-serving personnel and their families, I believe more effective policy and programs can be developed and health providers will be able to better meet the needs of serving members and contemporary veterans alike.

Finally, and most importantly, we will continue to look beyond medical circles and our international Defence counterparts to address mental health. This issue is bigger than us. It is a community issue. Our first responders—police, ambulance and emergency service personnel—are suffering too and Australia must accept that when we ask ordinary people to do extraordinary things on our behalf we owe them a duty of care. But more than that, we owe them a debt of gratitude and compassion. There is no shame in seeking help and until we, as a community, change our thinking to accept and acknowledge that, even the best mental health treatment programs in the world will fail because this is an issue for our nation, not just those we rely on to protect us.

Air Chief Marshal Binskin's service commenced in 1978 with the RAN. On completion of flying training, he was posted to fly A-4G Skyhawk aircraft. In 1982, he was selected as the first RAN pilot to undergo an exchange with the RAAF, flying Mirage III aircraft. On completion of this exchange and with the disbanding of the Navy's fixed wing capability, he joined the RAAF.

Air Chief Marshal Binskin's other flying tours include No 2 Operational Conversion Unit and No 77 Squadron at Williamtown, flying Mirage and F/A-18 aircraft; training on F/A-18 aircraft with the US Navy at Lemoore, California; instructing on F-16C aircraft with the US Air Force at Luke Air Force Base in Arizona; and No 75 Squadron at Tindal, Northern Territory, flying F/A-18 aircraft. His flying qualifications include Fighter Combat Instructor and Tactical Reconnaissance Pilot. Additionally, he has served as the RAAF F/A-18 Hornet Demonstration Pilot. He has over 3,500 hours in single-seat fighter aircraft.

Air Chief Marshal Binskin's command appointments include Commanding Officer of No 77 Squadron at Williamtown, Commander of Air Combat Group and later as Air Commander Australia. He has served in various joint staff positions, including Staff Officer to the Chief of the Defence Force and in the Defence Materiel Organisation as Officer Commanding the Airborne Early Warning and Control System Program Office. During Australia's 2003 contribution to the war in Iraq, Air Chief Marshal Binskin served as Chief of Staff at Headquarters Australian Theatre. Following this, he served as the Director of the US Central Air Force Combined Air and Space Operations Centre, where he was responsible for the conduct of coalition air operations in support of Operation IRAQI FREEDOM and Operation ENDURING FREEDOM.

Air Chief Marshal Binskin is a graduate of the Harvard Business School's Advanced Management Program, the Australian Institute of Company Directors and RAAF Command and Staff Course, where he was awarded the Chief of Staff's Prize for Professional Excellence. Air Chief Marshal Binskin was Chief of the Air Force from 2008-11, Vice Chief of the Defence Force from 2011-14 and was appointed Chief of the Defence Force on 30 June 2014.

Notes

- 1 This is an edited and updated version of a speech delivered as 'The Order of Australia Oration' in Canberra on 20 July 2015, available at <<http://video.defence.gov.au/play/Q4a2Zkdjo16Aw-2rlikVaK8DPAnfOF7#>>
- 2 G.E. Smith and T.H. Pear, *Shell Shock and Its Lessons*, Manchester University Press: Manchester, 1917.
- 3 M. Larsson, 'Unsung Healers: Anzacs and their family caregivers', *Memento* [National Archives of Australia], Issue 38, 2010, pp. 13-5.
- 4 M. Larsson, *Shattered Anzacs: living with the scars of war*, University of NSW Press: Sydney, 2009.
- 5 The reported figures were 1286 and 395 respectively.
- 6 Smith and Pear, *Shell Shock and Its Lessons*.
- 7 Smith and Pear, *Shell Shock and Its Lessons*, Chapter 1.
- 8 Smith and Pear, *Shell Shock and Its Lessons*, Chapter 1.
- 9 Smith and Pear, *Shell Shock and Its Lessons*, Chapter 4.
- 10 See, for example, Erica Goode, 'When Soldiers Snap', *New York Times* [website], 7 November 2009, available at <http://www.nytimes.com/2009/11/08/weekinreview/08goode.html?_r=0> accessed 12 August 2015.
- 11 A. McFarlane, 'One Hundred Years of Lessons about the Impact of War on Mental Health: two steps forward, one step back', *Australasian Psychiatry*, 3 June 2015.
- 12 R. Grinker and J. Spiegel, *Men Under Stress*, Blakiston: Philadelphia, 1945.
- 13 T. Wilkins, 'Lacking in Moral Fibre', *Defence of the Realm* [blog], 2 May 2015, available at <<https://defenceoftherealm.wordpress.com/2015/05/02/lacking-in-moral-fibre-lmf/>> accessed 12 August 2015.
- 14 See, for example, 'Australia and the Vietnam War', *Department of Veterans' Affairs* [website], available at <<http://vietnam-war.commemoration.gov.au/>> accessed 12 August 2015.
- 15 K. Muir, 'The Predisposition Theory, Human Rights and Australian Psychiatric Casualties of War', *Australian Journal of Human Rights*, Vol. 13, No. 1, 2007, pp. 198-215.
- 16 A. McFarlane and D. Forbes, 'The Journey from Moral Inferiority to Post-Traumatic Stress Disorder', *The Medical Journal of Australia*, Vol. 202, No. 7, 2015, pp. 348-9, available at <<https://www.mja.com.au/journal/2015/202/7/journey-moral-inferiority-post-traumatic-stress-disorder>> accessed 12 August 2015.
- 17 P.M. Clarke, R. Gregor and J.A. Salomon, 'Long-Term Disability Associated with War-Related Experience among Vietnam Veterans: retrospective cohort study', *Medical Care*, Vol. 53, No. 5, May 2015, pp. 401-8, abstract available at <<http://www.ncbi.nlm.nih.gov/pubmed/25768060>> accessed 12 August 2015.
- 18 A.C. McFarlane, S.E. Hodson, M. Van Hooff and C. Davies, *Mental Health in the Australian Defence Force: 2010 ADF mental health and wellbeing study: Full report*, Department of Defence: Canberra, 2011, available at <<http://www.defence.gov.au/Health/DMH/Docs/MHPWSReport-FullReport.pdf>> accessed 12 August 2015.
- 19 Department of Defence, 'ADF ARRTS Program', *Department of Defence* [website], available at <http://video.defence.gov.au/play/BmazhtdTqei_cjpnXpzWHeDJK3EjKLE#> accessed 12 August 2015.
- 20 Department of Defence, 'The Long Way Home: rehabilitation through the arts', *Department of Defence* [website], available at <<http://www.defence.gov.au/annualreports/13-14/features/feature-the-long-way-home.asp>> accessed 12 August 2015.
- 21 Department of Veterans' Affairs (DVA), 'Transition and Wellbeing Research Programme', *DVA* [website], available at <<http://www.dva.gov.au/health-and-wellbeing/research-and-development/social-research/transition-wellbeing-research>> accessed 12 August 2015; also Department of Defence, 'Mental Health Research and Evaluation', *Department of Defence* [website], available at <<http://www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp>> accessed 12 August 2015.