

Chapter 2

Prevalence of mental ill-health

Introduction

2.1 This chapter considers the extent and significance of mental ill-health in Australian Defence Force (ADF) members, veterans, and the families of ADF members and veterans.

Healthy soldier effect

2.2 When considering any occupational health study (and especially studies of military populations) it is important to note the 'healthy worker effect', in which people who are employed exhibit a lower mortality rate than the general population. This effect is often primarily attributed to a selection bias whereby people who are employed are, on average, healthier than the general population, which includes people who are severely ill or disabled and therefore unable to work. Military populations are, on average, far healthier than other employed populations, which are in turn healthier than the general population. The 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPW study) noted that:

The 'healthy worker effect' comes from the fact that, during recruitment, the ADF takes steps not to enlist individuals with pre-existing disorders. It then provides quality and accessible health services to all of its members. In addition, there is an occupational health service in the ADF that provides quality care at no cost to ADF members and, following deployment, ADF members are extensively screened to ensure they receive treatment if they need it. The ADF workforce should, therefore, be healthier than the general community.¹

2.3 Some occupational health studies of military cohorts refer to this as the 'healthy soldier effect'.² A number of submissions highlighted the importance of acknowledging the 'healthy soldier effect' when considering the prevalence of mental disorders for current and former ADF personnel.³ The Australian Families of the Military Research and Support Foundation (AFOM) asserted that 'research done in this area, which does not provide for the Healthy Soldier Effect (HSE) does not reflect the true extent and significance of the issues' and called for all future research to take the effect into account.⁴

1 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 2.

2 Department of Veterans' Affairs and Australian Institute of Health and Welfare, *Australian National Service Vietnam Veterans: Mortality and Cancer Incidence 2005*, p. 43.

3 Vietnam Veterans' Federation, *Supplementary Submissions 2.1 and 2.2*; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 7; and Partners of Veterans Association of Australia, *Submission 42*, p. 6; Phoenix Australia, *Submission 30*, p. 3.

4 Australian Families of the Military Research and Support Foundation, *Submission 26*, pp 7, 11.

Prevalence of mental ill-health in the Australian Defence Force

2.4 The MHPW study was the first comprehensive investigation of the mental health of an ADF serving population. The study examined the prevalence rates of the most common mental disorders, the optimal cut-offs for relevant mental health measures, and the impact of occupational stress factors. Nearly 49 per cent of ADF members serving during the time of the study (April 2010 to January 2011) participated.⁵

2.5 The MHPW study obtained normative mental health data from the Australian Bureau of Statistics (ABS) in order to interpret and fully understand the rates of mental disorders reported in the ADF. The ABS data, derived from the 2007 ABS National Survey of Mental Health and Wellbeing, was adjusted to match the demographic characteristics of the current ADF serving population (for age, sex, and employment status).⁶

2.6 The study found that more than half of the ADF population had experienced a mental disorder in their lifetime, a significantly higher rate than experienced by the general Australian population. The study noted that 'this level of mental illness in the ADF suggests that, despite the fact that the ADF is a selected and trained population that generally has better access to health care (the 'healthy worker effect'), this population is affected by a range of stress factors caused by the nature of their work'.⁷

Prevalence of mental disorders

2.7 The MHPW study found that 22 per cent of the ADF population (11,016) had experienced a mental disorder in the previous 12 months and that approximately 6.8 per cent (760) of those who had experienced a mental disorder had experienced more than one mental disorder at a time. The MHPW study noted that while the prevalence of mental health disorders in the previous 12 months was similar to the general Australian population sample, the profiles of specific disorders in the ADF varied.⁸ Table 2.1 provides the estimated prevalence of lifetime and 12-month mental disorders in the ADF and compares this to the ABS sample matched by age, sex, and employment status.

5 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. i.

6 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xv.

7 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xiv.

8 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xiv.

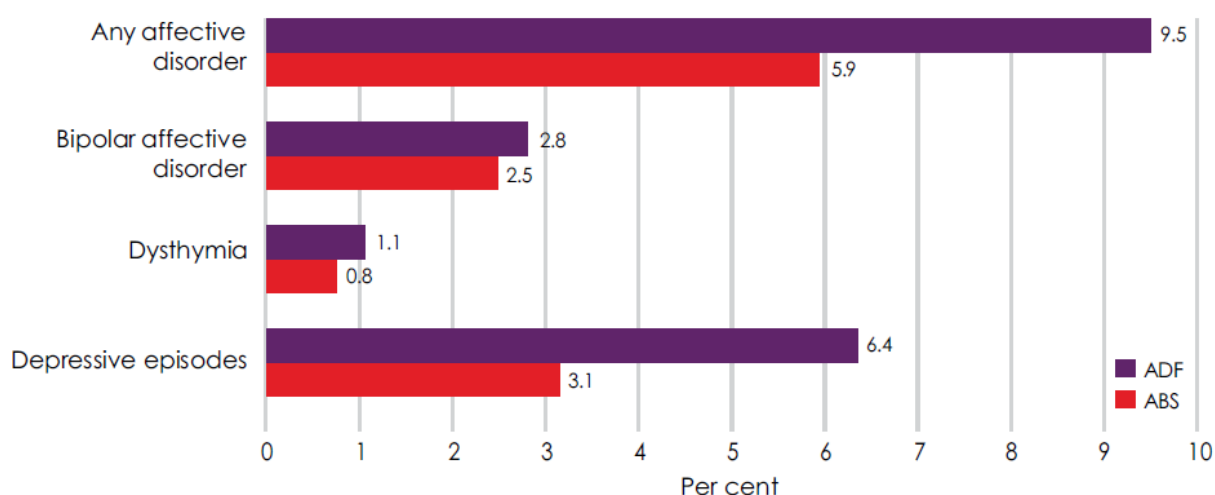
Table 2.1–Estimated prevalence of lifetime and 12-month disorders

	Lifetime prevalence		12-month prevalence	
	ABS %	ADF %	ABS %	ADF %
Any affective disorder	14.0	20.8*	5.9	9.5*
Any anxiety disorder	23.1	27.0	12.6	14.8
Any alcohol disorder	32.9	35.7	8.3	5.2*
Any mental disorder	49.3	54.1*	20.7	22.0

* Significantly different from the ABS study.

Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xv.

2.8 The MHPW study found that the most significant difference between the ADF population and the general Australia population sample was the prevalence of affective disorders (also known as mood disorders) (See Figure 2.1). It found that depressive episodes in both male (6.0 per cent) and female (8.7 per cent) ADF members were significantly higher than the general community rates (2.9 per cent and 4.4 percent respectively). There were no significant differences, however, between ADF males and ADF females in the prevalence of affective disorders.⁹

Figure 2.1–Estimated prevalence of 12-month affective disorders, ADF and ABS data

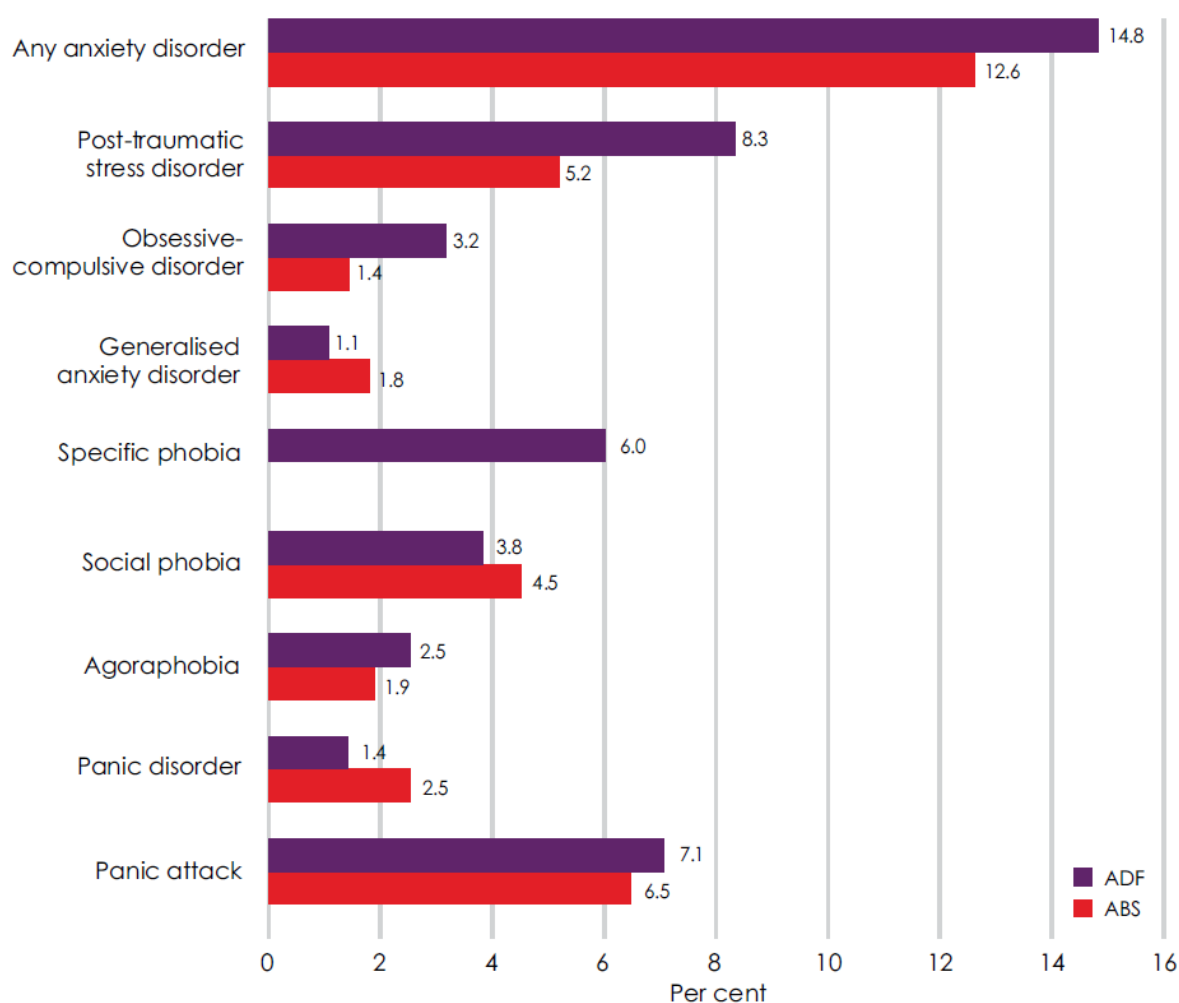
Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xix.

2.9 The MHPW study found that the most common mental disorders in the ADF were anxiety disorders, with the most prevalent anxiety disorder being post-traumatic

9 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xix.

stress disorder (PTSD) (see Figure 2.2). The overall prevalence of anxiety disorders was not found to be significantly higher than in the general Australian population. The primary difference between the ADF and the general Australian population was the significantly higher rates of PTSD in ADF males (8.1 per cent compared to 4.6 per cent) and the significantly lower rates of panic disorder in the ADF (1.2 per cent compared with 2.5 per cent). The study noted that, as is the case in the general Australian population, female ADF personnel rated higher than male ADF members on anxiety disorders and were significantly more likely to have panic attacks or panic disorder.¹⁰

Figure 2.2—Estimated prevalence of 12-month anxiety disorders, ADF and ABS data



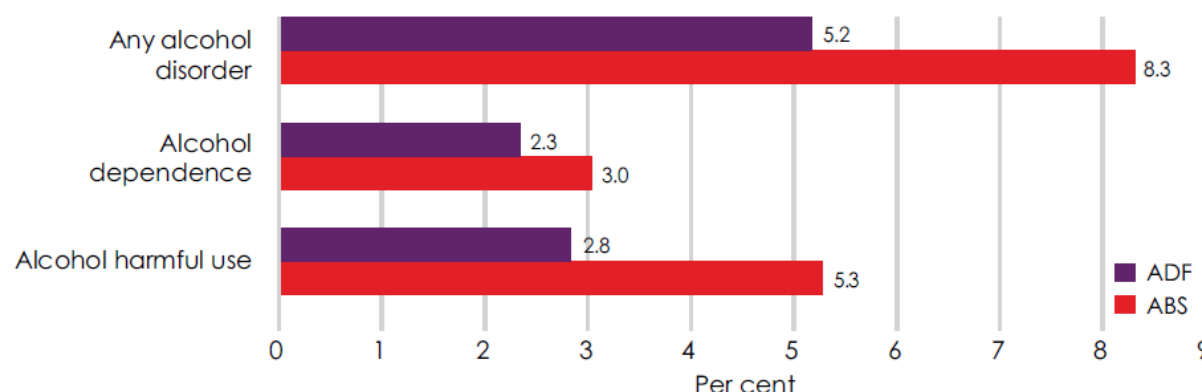
Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xix.

2.10 The MHPW study also found that both male (3.1 per cent) and female (1.3 per cent) ADF members had significantly lower rates of alcohol harmful use disorder compared to the general Australian population (5.5 per cent and 3.7 per cent

¹⁰ Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xx.

respectively) (See Figure 2.3). ADF females were significantly less likely to have an alcohol disorder than ADF males.¹¹

Figure 2.3–Estimated prevalence of 12-month alcohol disorders, ADF and ABS data



Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xx.

Future research

2.11 The Departments of Defence and Veterans' Affairs are currently funding the largest and most comprehensive study undertaken in Australia to examine the impact of military service on the mental, physical and social health of serving and ex-serving ADF personnel and their families. The Transition and Wellbeing Research Programme, led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide, consists of three studies: the Mental Health and Wellbeing Transition Study, the Impact of Combat Study, and the Family Wellbeing Study.¹²

2.12 The Mental Health and Wellbeing Transition Study will:

- determine the prevalence of mental disorders amongst personnel who have transitioned from full-time service between 2010 and 2014;
- examine the physical health status of serving and ex-serving personnel;
- investigate pathways to care for serving and ex-serving personnel, with a priority on those with a diagnosed mental disorder;
- examine factors that contribute to the current wellbeing of serving and ex-serving personnel;
- investigate how mental health issues change over time, especially once an individual transitions from full time service;

11 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xx.

12 Centre for Traumatic Stress Studies, *The Transition and Wellbeing Research Programme*, <http://health.adelaide.edu.au/ctss/research/transitionandwellbeingprogramme/>, accessed 16 July 2015.

- investigate technology and its utility for health and mental health programs, including implications for future health service delivery; and
- investigate the mental health and wellbeing of current serving reservists.¹³

2.13 The research program will survey a cohort of approximately 24,000 transitioned service personnel, together with current serving personnel and reservists (drawing from the Military and Veteran Research Study Roll)¹⁴ for the Mental Health and Wellbeing Transition Study and the Impact of Combat Study. The Family Wellbeing Study is being conducted by the Australian Institute of Family Studies and will survey family members nominated by the participants of the other two studies.¹⁵

2.14 The research program is also actively following up with all participants of the *2010 ADF Mental Health Prevalence and Wellbeing Study Report* as well as participants of the *Middle East Areas of Operations (MEAO) Census Health Study*. This will allow the research program to conduct both a prevalence study and a longitudinal follow up.¹⁶

2.15 Prior to its closing in December 2014, the Centre for Australian Military and Veterans' Health conducted epidemiological studies that provide a comprehensive picture of the health of serving members, veterans, and their families following specific deployments including:

- Rwanda Deployment Health Study (2014);
- Middle East Area of Operations (MEAO) Health Study – Mortality and Cancer Incidence Study (2013);
- Middle East Area of Operations (MEAO) Health Study – Census Study (2012);
- Middle East Area of Operations (MEAO) Health Study – Prospective Study (2012);
- Timor-Leste Family Study (2012);
- Bougainville Health Study (2009);
- East Timor Health Study (2009); and

13 Centre for Traumatic Stress Studies, *The Transition and Wellbeing Research Programme*, <http://health.adelaide.edu.au/ctss/research/transitionandwellbeingprogramme/>, accessed 16 July 2015.

14 Department of Defence, *Mental Health Research and Evaluation*, <http://www.defence.gov.au/Health/DMH/ResearchSurveillancePlan.asp>, accessed 16 July 2015.

15 Information provided over the phone by Ellie Lawrence Wood from the Centre for Traumatic Stress Studies on 16 July 2015.

16 Information provided over the phone by Ellie Lawrence Wood from the Centre for Traumatic Stress Studies on 16 July 2015.

- Solomon Islands Health Study (2009).¹⁷

Linking research to policy

2.16 Dr Annabel McGuire noted that whilst research studies have added to the fundamental scientific understanding of the impact of military service on ADF personnel and their families, 'the biggest flaw in this work was that the Departments and the research teams failed to work together to translate the findings into actionable policy and programs' and that the research was generally not well received by the broader Defence community:

In general terms, the research has not been well received by the broader Defence community, in part because scientific reports do not tell people's story: reading that eight percent of the Defence Force has screened positive for PTSD in the past year does not feel right when you look around and can see four guys in your section are struggling. The answer to this problem is not to commission new and bigger research projects aiming to be the panacea for the failings of previous research. The disenfranchised ex-service community does not respond well to another survey from which they see no outcome. Research must be explicitly and overtly linked to changes in policy and/or practice.¹⁸

Heightened risk factors of service

2.17 The Chief of the Defence Force, Air Chief Marshal Mark Binskin AC, told the committee that Defence 'acknowledge[s] that military service creates unique stresses'¹⁹. DVA explained that the 'day to day stressors of military service can include significant periods away from home, family and friends while on posting and reduced access to social and family supports, including the impact on spouses and children'.²⁰

Impact of deployment on mental health

2.18 As at January 2011, approximately half of all ADF personnel have been deployed multiple times. In the MHPW study, 43 per cent of ADF personnel participating reported being deployed multiple times, 19 per cent reporting being deployed once and 39 per cent never having been deployed.²¹ Every year, approximately 12,000 ADF personnel are in the 'operational deployment cycle', meaning that they are preparing, deploying or transitioning home.²²

17 Centre for Australian Military and Veterans' Health, *Deployment Health Surveillance*, <http://www.camvh.org.au/index.html?page=216371&pid=110145>, accessed 18 January 2016.

18 Dr Annabel McGuire, *Submission 24*, p. 2.

19 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, Department of Defence, *Committee Hansard*, 21 September 2015, p. 1.

20 Department of Veterans' Affairs, *Submission 35*, p. 17.

21 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. i.

22 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. v.

2.19 Between July 2013 and June 2014, 896 ADF personnel were referred to the ADF Rehabilitation Program with a primary diagnosis of a mental health disorder. Of these, 33.6 per cent were identified as being 'deployment related'. In this period, 206 of the 896 personnel were referred with a specific diagnosis of PTSD, of which 84 per cent were identified as being 'deployment related'. Since 2000, 108 ADF personnel are suspected or confirmed to have died as a result of suicide, of which 47 had previously deployed.²³

2.20 The findings of the MHPW study indicated that there was no significant link between deployment and an increased risk of developing PTSD, anxiety, depression or substance abuse disorders, stating that 'deployed personnel did not report greater rates of mental disorder than those who had not been deployed'.²⁴ However, the Chief of the Defence Force acknowledged that the risk of experiencing a traumatic event increases during deployment and that exposure to trauma increases the risk of poor mental health outcomes:

Our research clearly shows that exposure to trauma increases a person's risk of developing a mental health condition or problem, as you would expect. Some people will be exposed to trauma while on operations. Others may experience traumatic events outside a deployment or military service. Despite reports to the contrary, we fully accept that the risk of experiencing a traumatic event increases during a deployment whether it be to a conflict zone, during a humanitarian or disaster relief mission or in border protection operations.²⁵

2.21 Defence advised that for the majority of ADF members who have been deployed on a warlike operation (81.7 per cent), their cumulative time on a warlike operation equates to one year or less (see Table 2.2).

Table 2.2—Cumulative time on a warlike operation

Time	1 year or less	Between 1 and 2 years	Between 2 and 3 years	More than 3 years
ADF members	40,959 (81.7 per cent)	8,367 (16.7 per cent)	737 (1.5 per cent)	56 (0.1 per cent)

Department of Defence, answer to question on notice, 2 June 2015 (received 15 July 2015).

²³ Department of Defence, *Submission 34*, p. 6.

²⁴ Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. i.

²⁵ Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, Department of Defence, *Committee Hansard*, 21 September 2015, p. 1.

Exposure to traumatic events

2.22 The Australian Psychological Society noted that 'it is well known that the unique occupational risks of ADF service include significant exposure to potentially traumatic events'.²⁶ The MHPW study agreed, noting that:

...members of the ADF are at risk of developing mental disorders, as they are exposed to a range of occupational stressors – for example, exposure to traumatic events and extended periods of time away from their primary social support networks.²⁷

2.23 Defence reported that the most common potentially traumatic event reported by deployed personnel in the Return to Australia Psychological Screening in Annual Mental Health Surveillance Reports has consistently been 'in danger of being injured', followed by 'in danger of being killed'. Defence noted that this was different for Navy personnel deployed on Operation Resolute, who reported in the Mental Health and Wellbeing Questionnaire that the most common exposure was 'witnessed human degradation/misery on a large scale' followed by 'in danger of being injured'.²⁸

2.24 In addition to considering the number of traumatic experiences, the MEAO report also considered the types of traumatic combat-related experiences associated with PTSD symptoms. The MEAO study found that participants who reported experiencing five or more types of traumatic exposure were statistically significantly more likely to have adverse psychological health outcomes.²⁹ The MEAO study found that exposures such as 'threatening situation and unable to respond', 'handling/seeing dead bodies', and 'being witness to human degradation and misery' were strongly and statistically associated with PTSD symptoms.³⁰

2.25 The MHWP study also considered the proportion of those personnel exposed to traumatic events that go on to develop PTSD (see Figure 2.5). The event associated with the highest rates of PTSD was 'being kidnapped or held hostage', with 78.5 per cent of those who had experienced this event having PTSD. Other events that were associated with very high rates of PTSD were rape (42.3 per cent), being stalked (38.4 per cent), and domestic violence (31.1 per cent). The rate of PTSD for serving as a peacekeeper (9.2 per cent) and combat experience alone (10.4 per cent) were comparatively quite low. The MHWP study commented that:

In summary, these results provide an insight into the fact that certain aspects of military service such as combat or peacekeeping do not per se present major risks to post-traumatic stress disorder. Rather, it is likely that

26 Australian Psychological Association, *Submission 22*, p. 3.

27 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 2.

28 Department of Defence, *Submission 34*, p. 5.

29 Centre for Military and Veterans' Health, *The Middle East Area of Operations (MEAO) Health Study: Census Study Report*, 14 December 2012, p. 73.

30 Centre for Military and Veterans' Health, *The Middle East Area of Operations (MEAO) Health Study: Census Study Report*, 14 December 2012, p. 68.

there are certain experiences within military service, such as seeing atrocities or accidentally injuring or killing another individual, which may be particularly damaging to an individual's psychological health.³¹

2.26 DVA advised the committee that in addition to the risk of exposure to potentially traumatic experiences during deployment, ADF members may also be exposed to potentially traumatic experiences during peacetime service activities, for example during disaster assistance or as a result of serious training accidents:

Any military service involves risk of exposure to traumatic experiences, such as trauma arising from disaster assistance or serious training accidents. For instance, in 1996 two Black Hawk helicopters collided and crashed at the High Range Training Area near Townsville, resulting in the deaths of 18 personnel and injuries to a further 12 personnel. In 2005, a Sea King helicopter crashed on Nias Island in Indonesia while on a humanitarian support mission, with the deaths of 9 ADF personnel.³²

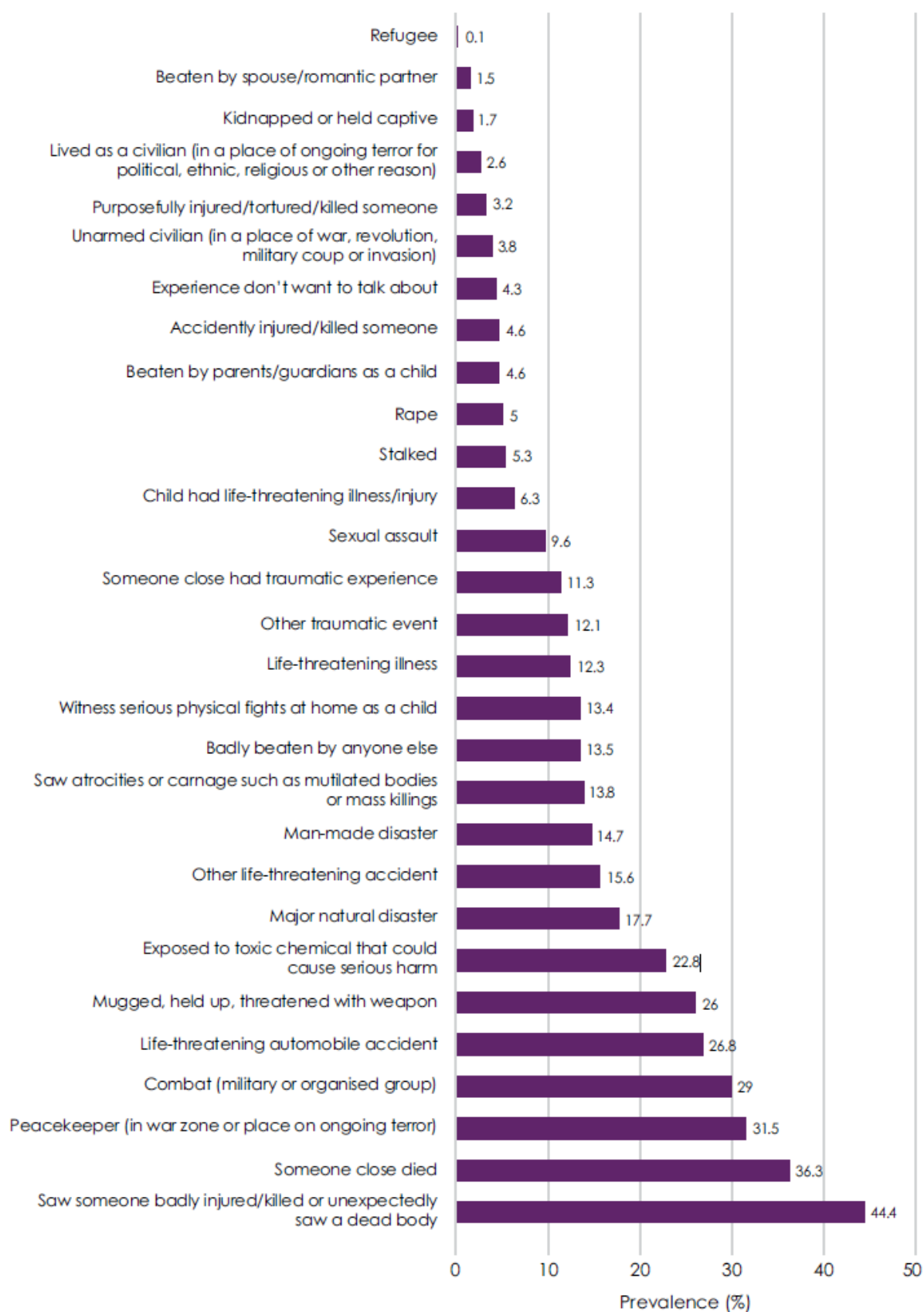
2.27 The MHWP study commented on the difficulty of clearly differentiating between traumas experienced during ADF service and traumas experienced in ADF members' private lives, noting that for clear conclusions to be drawn regarding the impact of ADF service 'traumas experienced during military service and in the private lives of ADF members need to be separated'.³³

31 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 51.

32 Department of Veterans' Affairs, *Submission 35*, p. 17.

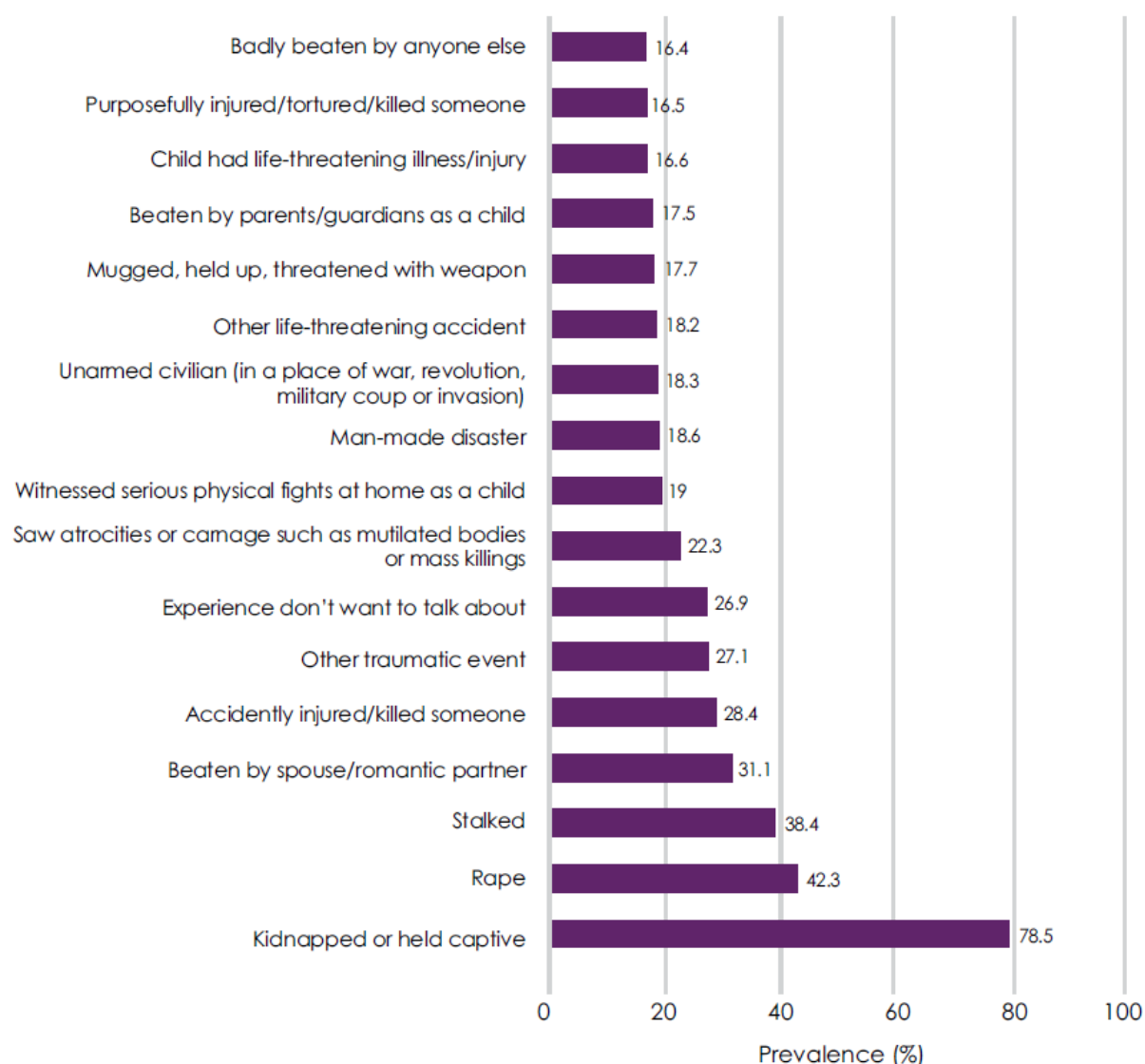
33 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 51.

Figure 2.4—Estimated prevalence of lifetime trauma exposure in the ADF



Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 49.

Figure 2.5–Estimated prevalence of post-traumatic stress disorder from specific event types



Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 50.

2.28 The committee received powerful evidence from veterans who described the traumatic experiences that they were exposed to during their service and the impact that it has had on their mental health. Slater & Gordon gave numerous examples of clients' traumatic experiences on deployment. A veteran soldier and combat first-aider who was deployed to Afghanistan and suffers from chronic PTSD stated:

I was a scout in my section and we were doing a cordon and research mission. I was providing security when the IED went off...I first came across Private [name omitted] who had his leg blown off, he had a tourniquet on and was being treated; I was stunned for a split second. People were screaming and shouting. I then realised my friend [name omitted] had been killed. There were bits of his body, his body armour and kit strewn across the field. There was a child that had his toes blown off from the blast that had begun running away from us at that point. There were three Afghan civilians lying on the ground who had major blast

injuries and who I commenced treating. After the first helicopter took the Private away and the second helicopter took the civilians, the last helicopter came to get the last casualty and my friend's body. As I loaded the last casualty onto the helicopter it hit me when I saw his name written across his body bag, my heart sank as the realisation of what happened set in. The helicopter took off and my sergeant asked me to help him pick up some body parts that had been forgotten in the chaos.³⁴

2.29 The following was conveyed by Slater & Gordon Lawyers from a returned servicemen of the East Timor Peacekeeping Mission suffering PTSD and depressive symptoms and who attempted suicide during deployment:

During my deployment there we were also stopped by distressed locals during one of our patrols. The Timorese led our patrol section to a burnt out building...towards the back of the building in one of the rooms, there was a local woman. The woman was deceased and surrounding her was an evident smell of fuel. I drew my own conclusion that she appeared to have been doused with petrol, set alight and shot in the head. We carried her outside and once in the open, I could see the poor woman was a mother.

Fused to her was the baby that she must have been holding at the time of her execution...I see this woman and her child whilst sleeping and often for no reason start to think of her during my day to day goings on. I feel ashamed that I was not there fast enough to stop what happened. I feel angry that a helpless woman and her baby were killed in such an inhumane manner. I cannot seem to shake what happened to her and feel immense anger at how an innocent child was burnt (most possibly whilst it was still alive). I am haunted by this and often find myself getting teary. It just doesn't go away.³⁵

2.30 Mr Matthew McKeever told the committee of his repeated exposure to highly traumatic situations across five deployments during his 16 years of service:

I killed my first person on 30 August 2010—retrieved the body; you are required to fingerprint it and required to iris scan. I was offered no mental support after that. I then had dealings with other dead Taliban who were killed by other people where I was required to physically examine them for bullet holes. On occasion when I would lift their arms up my fingers would go through their wrists from the bullet holes. Because of that, I have no sexual function. I have to inject myself with a needle; I can show you it. If I try to have sexual intercourse with my partner, I get flashbacks from my fingers going into dead people. So I have to inject my penis with a needle of the size I am showing you—it is quite large—which is not nice. So I have no sexual life, and I have not slept with my wife for over 12 months due to severe nightmares.

My second deployment to Afghanistan was totally different. My first one was high activity with numerous contacts, numerous IED explosions and

34 Slater & Gordon Lawyers, *Submission 51*, p. 2.

35 Slater & Gordon Lawyers, *Submission 51*, pp 4–5.

handling numerous dead bodies. My second one was quite different. I knew I had a problem, but then I was exposed to the handling of dead children. In one instance with one child, I had to pick the little boy up by his ankles and shake him to prove to his parents that he was deceased. Then when I returned from Afghanistan I tried to commit suicide because I saw my child and that brought back a lot of memories.³⁶

2.31 Mr McKeever acknowledged that the risk of exposure to traumatic experiences is inherent to deployment as an infantry soldier but asserted that the risk is poorly managed. Mr McKeever pointed to policies that increased exposure to potentially traumatic experiences for soldiers who must 'process' (iris and finger print scan) the human remains of those they have killed. Mr McKeever called for specialised teams of medical officers to process human remains to minimise this risk:

I know what an infantry soldier does. But there should be people in specialised areas, as they had in East Timor and other places, so that when you kill somebody and they have to be dragged out and processed, there is a specialist team that comes out and does that—medical officers. I told my soldiers, 'If you do not have to see the dead body, don't see it.'³⁷

2.32 Defence advised the committee that the collection of biometric information, as referred to by Mr McKeever, is authorised by and must comply with Defence Instructions (General) Operations 13-16 which states, 'biometric samples, including collection by invasive techniques, may be taken from human remains but only if this can be done without mutilating or otherwise maltreating the remains. The utmost respect is to be shown to human remains at all times'. Defence noted that the approach and manner in which ADF members' process human remains is shaped by the requirements of the operation as well as the operational environment and tactical situation.³⁸ Defence's policies regarding operational mental health and psychology support in the pre-deployment, deployment, and post-deployment phases are discussed in Chapter 3 of this report.

Abuse

2.33 The ADF has had a long history of incidents of reported abuse and harassment (including sexual abuse) within its ranks. The Senate Foreign Affairs, Defence and Trade References Committee has previously conducted inquiries which have addressed, or touched upon, abuse and sexual harassment in Defence. These inquiries have included:

- Processes to support victims of abuse in Defence (October 2014);
- Report of the review of allegations of sexual and other abuse in Defence, conducted by DLA Piper, and the response of the government to the report (June 2013);

36 Mr Matthew McKeever, *Committee Hansard*, 1 September 2015, pp 34-35.

37 Mr Matthew McKeever, *Committee Hansard*, 1 September 2015, pp 34-35.

38 Department of Defence, answer to question on notice, 2 February 2016 (received 12 February 2016).

- Inquiry into an equity and diversity health check in the Royal Australian Navy – HMAS Success (September 2011);
- The Effectiveness of Australia's military justice system (June 2005); and
- Sexual Harassment in the Australian Defence Force (August 1994).³⁹

2.34 A number of submissions commented negatively on 'ADF culture' and detailed members' and veterans' personal accounts of abuse in the ADF and its effect on mental health.⁴⁰ Mr Ciaran Hemmings told the committee of his experience of abuse following a physical injury and its impact on his mental health:

I have done six years in Defence. I did not deploy. I sustained my injury whilst on rifle combat at Butterworth over in Malaysia on a training exercise. I crushed my right arm whilst over there. Mental health within Defence is—like [Mr McKeever] said, they do not care at the end of the day. The names you get called—I have got a body suit because I have got severe nerve pain. I also suffer from adjustment disorder with anxiety and depression. And in the pack mentality of Defence that does not sit well, as [Mr McKeever] said, and probably the others. As soon as you are injured, you are like a dog—you are kicked out of the pack and there is no way of getting back into that pack. I was injured in 2013. I tried my hardest to get better, but the ridicule within Defence was phenomenal. Every time I tried to do something it would be like, 'Don't do that—you might hurt your other hand' or 'Come on, Michael Jackson, give us a moonwalk'. It is shocking. It just makes the mentality worse. You can speak to hierarchy about it and you get ridiculed also, like officers and so forth. You get to the point where you fear to even speak up...It just came to the point where I had to go to the doctor on base myself and ask for help because I was the same: I was at the point where I would sit at home at night and think about suicide. It got really hard, to the point where—I have got three children—it come down to being there for my kids. I could not do this without help and seeing [Dr Niall McLaren, psychiatrist]. The way work treated you—I hated going to work. I would sit at the back gate and struggle for half an hour to even drive into that place knowing that as soon as you did you would just get ridiculed and picked on for your condition.

It is massive in Defence and it is not looked at at all. I spoke up to mates, and stuff like that, and they would just say, 'Harden up, princess. It's not that bad.' But once you have got an injury and you are kicked out of the pack, and because you have got your brethren and your mates and stuff, the next minute you are pushed off to the side, literally. They will grab you and

39 All reports are available from the committee's website http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade

40 For example: Returned & Services League of Australia, *Submission 19*, pp 14–15; Mr John Skewes, *Submission 52*, p. 2; Major Stuart McCarthy, *Submission 54*, p. 1; Name withheld, *Submission 57*, pp 1–2; Mr John Lawler, *Submission 58*, pp. 1–7; Name withheld, *Submission 70*, pp 1–10.

they will sit you in another building away from all the non-injured personnel. That is where you sit until you are kicked out.⁴¹

2.35 Although not the subject of this inquiry, it is important to acknowledge the enormous impact that harassment, bullying, and abuse (sexual and otherwise) may have on the mental health of both the subject of harassment, bullying, and abuse as well as witnesses. Chapter 5 of this report will consider the stigma associated with mental ill-health and its impact in greater detail.

Prevalence of mental health disorders in veterans

2.36 The Department of Veterans' Affairs (DVA) informed the committee that as at March 2015, it was supporting 147,318 veterans with one or more disabilities accepted by DVA and of these, 49,668 veterans had one or more accepted mental health disabilities (See Table 2.3). DVA advised the committee that there are two pathways by which veterans may apply to DVA:

- the liability pathway: if they have mental health conditions related to service in the ADF, in order to receive compensation and treatment; and
- the non-liability pathway: if they have certain mental health conditions whatever the cause, in order to receive treatment only.

Table 2.3–Veterans with mental health conditions accepted by DVA, March 2015*

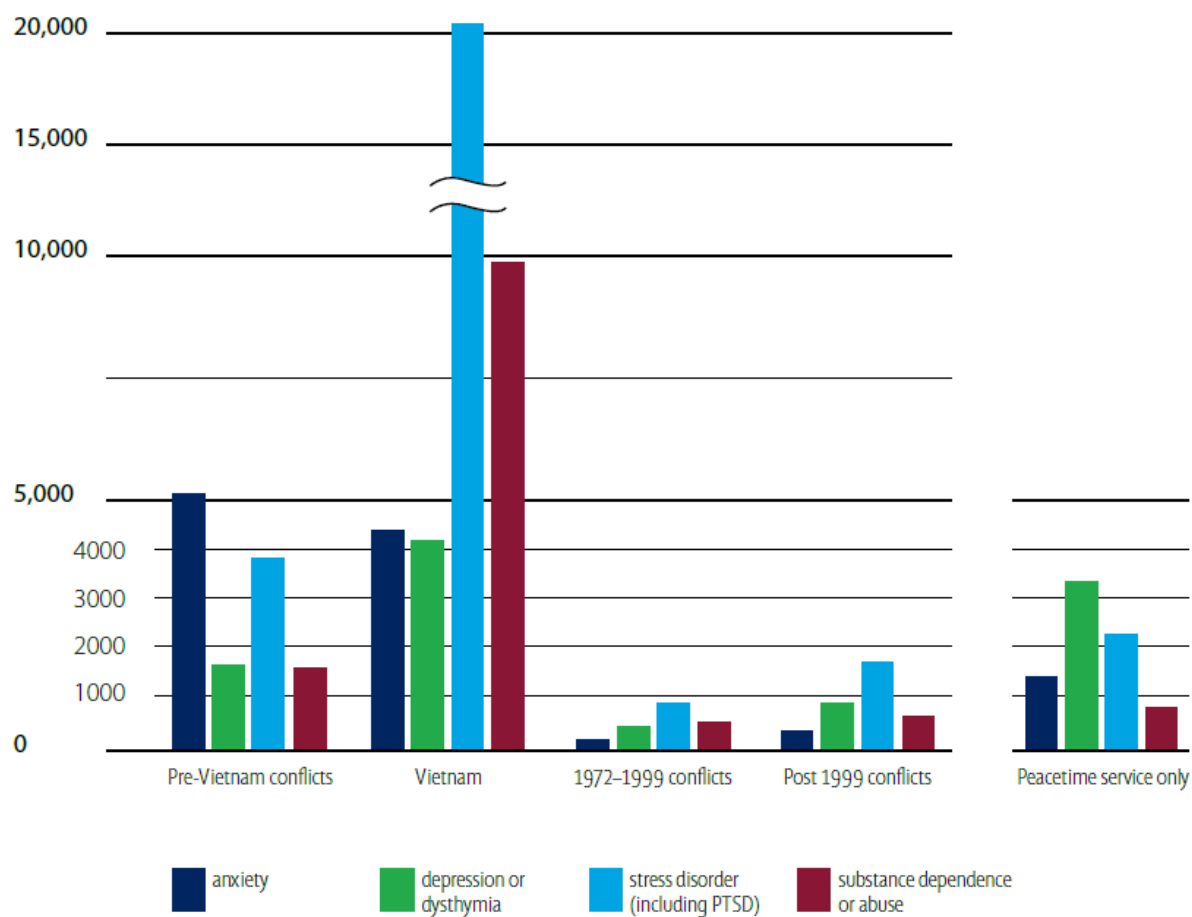
Number of veterans with	Related to service (liability)	For any cause (non-liability)	Net total
One or more accepted disabilities	143,652	34,451	147,318
One or more accepted mental health disabilities	45,953	15,526	49,668
PTSD and other stress disorders	28,875	11,705	31,501
Depression or dysthymia	11,649	4,102	13,976
Alcohol and other substance use disorders	13,273	322	13,532
Anxiety	10,406	2,214	11,932
Adjustment disorder	1,911	N/A	1,911

* Note: This table is a count of claims. Some individuals are counted multiple times.

Department of Veterans' Affairs, *Submission 35*, p. 12.

2.37 Figure 2.6 sets out the top mental health conditions, as at March 2013, grouped into conflict cohorts.

Figure 2.6–Top mental health conditions as at March 2013, includes VEA, MRCA & SRCA



Department of Veterans' Affairs, *Veteran Mental Health Strategy: A Ten Year Framework 2013-2023*, p. 28.

2.38 Table 2.4 shows the number mental health claims accepted by DVA each year over the past decade; a rate of between 3,100 and 5,350 claims per year.

Table 2.4–Flow of accepted mental health claims accepted by DVA, January 2015

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Related to service (liability)	4,185	3,764	3,160	3,197	2,928	2,779	2,458	2,332	2,748	3,412	3,579
For any cause (non-liability)	1,158	1,228	1,146	819	841	880	786	758	956	1,149	1,680
Net total	5,343	4,992	4,306	4,016	3,769	3,659	3,244	3,090	3,704	4,561	5,259

* Note: some veterans are counted multiple times if they have more than one condition.

Department of Veterans' Affairs, *Submission 35*, p. 12.

2.39 The Returned & Services League of Australia (RSL) questioned the numbers provided by DVA, asserting that the potential number of veterans with service-related mental health problems could be significantly higher, noting that it is estimated that only one in five veterans have DVA client numbers:

Senator Michael Ronaldson, Minister for Veterans' Affairs, reports that DVA clients number approximately one in five of all Australians who have service in the ADF. Using DVA's approximate current client numbers of 330,000, this means that the potential number of veterans suffering service-related mental ill-health could be significantly higher than those who have lodged claims.

As ex-serving members are not compelled to register with DVA unless they want to claim for a service-related injury or illness, the extent of mental ill-health among ex-serving men and women is unknown. Given the typical presentation some eight to 10 years after discharge and the experience following the Vietnam War of delayed onset of symptoms, it is highly likely that there are significant numbers of veterans with service related mental ill-health who are as yet unknown to DVA.⁴²

2.40 Phoenix Australia noted that 'many mental health problems may not be obvious while the person is still serving and may not become apparent until months or years after serving'.⁴³ The RSL commented that 'the lack of information in this area is concerning but the sheer numbers of veterans seeking RSL support alone is enough to indicate that this is a severe problem'.⁴⁴ Soldier On also expressed concerns with DVA data, noting that 'once a person discharges from the military there are no records kept of their on-going or developing physical or mental health concerns, hospitalisation or deaths unless the treatment is provided through DVA'.⁴⁵

42 Returned & Services League of Australia, *Submission 19*, p. 6.

43 Phoenix Australia, *Submission 30*, p. 10.

44 Returned & Services League of Australia, *Submission 19*, p. 6.

45 Soldier On, *Submission 29*, p. 6.

2.41 The record-keeping policies and processes for both Defence and DVA will be considered in greater detail in Chapter 5 of this report.

Suicide

2.42 Suicide is a leading cause of death in Australia. In 2013, deaths due to suicide occurred at a rate of 10.9 per 100,000 people. The median age at death for suicide was 44.5 years for males, 44.4 years for females, and 44.5 years overall. In comparison, the median age for deaths from all causes in 2013 was 78.4 years for males and 84.6 years for females.⁴⁶ Of deaths due to suicide, 75 per cent are male, making it the tenth leading cause of death for males in Australia.

Suicidality in ADF population

2.43 Defence advised the committee that since 2000, 108 ADF members are suspected or have been confirmed to have died as a result of suicide.⁴⁷ The MHPW study found that the rate of suicidality (thinking of suicide and making a suicide plan) in the ADF was more than double that in the general community; however the number of suicide attempts was not significantly greater than in the general community and the number of reported deaths by suicide in the ADF were lower than in the general population when matched for age and sex. The study noted that there is a gradation of severity of suicidality in the ADF, ranging from those with suicidal ideation (3.9 per cent) through to those making a plan (1.1 per cent) and those actually attempting suicide (0.4 per cent) (see Table 2.5).

Table 2.5—Estimated prevalence of 12-month suicidality, by sex, ADF and ABS data

	Males		Females		Total	
	ABS %	ADF %	ABS %	ADF %	ABS %	ADF %
Felt so low that you thought about committing suicide	1.5	3.7*	2.8	5.1*	1.7	3.9*
Made a suicide plan	0.3	1.1*	0.5	1.2*	0.4	1.1*
Attempted suicide	0.3	0.4	0.4	0.5	0.3	0.4
Any suicidality	1.6	3.8*	2.8	5.1*	1.8	4.0*

* Significantly different from the ABS study.

Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xxi.

2.44 The MHPW study commented that although ADF members are more symptomatic and more likely to express suicidal ideation than people in the general community, they are only equally likely to attempt suicide and less likely to complete the act, and that this suggests that 'the comprehensive initiatives on literacy and

46 Australian Bureau of Statistics, *3303.0 – Causes of Death, Australia, 2013*.

47 Department of Defence, *Submission 34*, p. 6.

suicide prevention currently being implemented in Defence may, in fact, be having a positive impact'.⁴⁸

Suicidality in ex-service population

2.45 DVA informed the committee that it has determined 85 claims relating to death by suicide over the last ten years (to 31 December 2014). Of the 85 claims, 57 were accepted as service related; and of the 57 claims, 22 veterans were aged 55 years or under at death. DVA advised that it is only made aware of a death by suicide when a dependant lodges a compensation claim:

Generally, DVA only becomes officially aware of a death by suicide of a veteran through the dependant's compensation claim process. This occurs when a claim for compensation is lodged by a dependant in respect of the death of that veteran and a cause of death must be investigated to establish a link to service.⁴⁹

2.46 A number of submissions highlighted the difficulty of accurately estimating suicidality of veterans and expressed concern about the lack of data regarding veteran suicide.⁵⁰ Some submitters called for the government to monitor and maintain a public record of suicide, suspicious death, single vehicle accidents and other deaths by misadventure.⁵¹ The RSL also noted that suicide data is further complicated by deaths that are not definitively confirmed to be suicides:

When death occurs as a result of self-harm in association with existing mental health difficulties, unless it is very clear, e.g. self-inflicted injury or overdoses, then the cause of death is very often left open by the coroner. This action produces inaccurately low figures with regard to suicide figures particularly when substance abuse, motor vehicle accidents and cliff falls are involved. In addition there may be no mention of a mental health history on the death certificate at all.⁵²

48 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xiv.

49 Department of Veterans' Affairs, *Submission 35*, p. 18.

50 For example: Vietnam Veterans' Federation of Australia, *Submission 2* (see also supplementary submissions and attachments); Mr Douglas Steley, *Submission 6*, p. 6; Mr Robert Shortridge, *Submission 16*, p. 4; Walking Wounded, *Submission 18*, p. 3; Returned & Services League of Australia, *Submission 19*, p. 8; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 12; Soldier On, *Submission 29*, pp 6–7; Name withheld, *Submission 44*, p. 2; Royal Australian Regiment Association, *Submission 46*, pp 2–4; Dr Niall McLaren, *Submission 50*, pp 3–4; Slater & Gordon Lawyers, *Submission 51*, p. 6; Name withheld, *Submission 70*, p. 3; KCI Lawyers, *Submission 71*, p. 5; Mr Phil Hay, *Submission 72*, p. 4.

51 For example: Mr Douglas Steley, *Submission 6*, p. 6; Walking Wounded, *Submission 18*, p. 3; Returned & Services League of Australia, *Submission 19*, p. 8; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 12; Soldier On, *Submission 29*, pp 5–6; Slater & Gordon Lawyers, *Submission 51*, p. 6.

52 Returned & Services League of Australia, *Submission 19*, p. 8.

2.47 Soldier On stressed the importance of accurate and transparent data regarding veteran suicide noting that without accurate data it is impossible for both government and non-government support providers to properly address the issue:

...very little is known about how many veterans are taking their own lives. Community groups are gathering anecdotal data, but without any reliable sources collecting the information, it is impossible for any support provider (government or non-government) to truly understand the extent of the issue...it is our recommendation that data around the ongoing health implications among serving and ex-serving members over the past five to 10 years is collated as a priority by the Department of Veterans' Affairs. It is also important this information is gathered regularly and made available to the public in a de-identifiable format, in order for the issues to be quantified and a reasoned response and solution be prioritised.⁵³

2.48 DVA advised the committee that in November 2014 it commissioned the Australian Institute of Health and Welfare to carry out a data matching exercise between deceased military superannuants from ComSuper and the National Death Index for reported incidents of suicide from 2001 onwards. DVA advised that it expects to receive the findings from this work in late 2016.⁵⁴ DVA has also commissioned the Australian Institute for Suicide Research and Prevention (Griffith University), to conduct a literature review to examine suicide amongst veterans in Australia and internationally, and how this compares to the general population.⁵⁵

2.49 Recent research into suicidality in Australian Vietnam veterans and their partners found that suicidality was higher in veterans than in the Australian community. The study assessed the lifetime suicidality of a cohort of 448 Australian Vietnam veterans during in-person structured psychiatric interviews that permitted direct comparison with age-sex matched Australian population statistics finding that:

Relative risks for suicidal ideation, planning and attempts were 7.9, 9.7 and 13.8 times higher for veterans compared with the Australian population ...PTSD, depression, alcohol disorders, phobia and agoraphobia were prominent predictors of ideation, attempts and suicidal severity among veterans.⁵⁶

2.50 Similarly, the 2005 Australian National Service Vietnam Veterans: Mortality and Cancer Incidence report found that there was a significant increase in the relative rate for suicide for veterans:

There was a significant increase in the relative rate for suicide, based on 129 deaths observed amongst the National Service veterans and 115 deaths

53 Soldier On, *Submission 29*, pp 6–7.

54 DVA advised in its submission that it expected to receive the findings for this exercise in late 2015; however, on 15 January 2016 DVA advised the committee via email that this date has since been revised to late 2016.

55 Department of Veterans' Affairs, *Submission 35*, p. 18.

56 Brian O'Toole, *et al.*, 'Suicidality in Australian Vietnam veterans and their partners', *Journal of Psychiatric Research*, vol. 65, June 2015, p. 30.

observed amongst non-veterans. This gave a relative rate of 1.43...this relative rate was higher than that noted in the previous study of this cohort.⁵⁷

2.51 Dr Kieran Tranter pointed to the Veterans Line statistics as a possible means of providing insight into veteran suicidality, noting with concern the increasing number of clients identified as at significant risk of suicide or self-harm:

The Veterans Line also provides a call-back service for clients who may present as being at significant risk of suicide or self-harm. In 2012-13 the service identified and made 52 call-backs to veterans who presented such risks compared to only 21 call-backs in 2011-12. The number of call-backs made in 2013-14 rose significantly again to 122 clients being identified as requiring the call back service...these figures are alarming, as the numbers of clients who have been identified as at significant risk of suicide or self-harm have doubled each year since 2011-2012.⁵⁸

Prevalence of mental ill-health in families of ADF members and veterans

2.52 A number of submissions highlighted the impact ADF members and veterans struggling with mental ill-health can have on their families.⁵⁹ The War Widows' Guild of Australia told the committee that 'veterans with PTSD/mental ill-health issues have impacts on the entire family', explaining that the mental health of the families of ADF members and veterans are impacted as a result of the ADF member or veterans' service:

There is anecdotal evidence that many War Widows have suffered forms of abuse, be it physical, emotional or psychological as a result of their spouse/partner/significant others service in an area of conflict. These women have been reluctant to discuss their issues for fear of social rejection, isolation, embarrassment, feeling that this violence is 'their fault' rather than as a symptom of their spouses/partners mental ill-health.⁶⁰

57 Department of Veterans' Affairs, *Australian National Service Vietnam Veterans: Mortality and Cancer Incidence 2005*, p. 46.

58 Dr Kieran Tranter, *Submission 27*, p. 26.

59 For example: Vietnam Veterans' Federation of Australia, *Submission 2* (see also supplementary submissions and attachments); Returned and Services League of Australia, *Submission 19*, p. 3; Australian Psychological Society, *Submission 22*, pp 3, 11; Psychotherapy & Counselling Federation of Australia, *Submission 23*, pp 9–11; Dr Annabel McGuire, *Submission 24*, pp 2–3; Australian Families of the Military research and Support Foundation, *Submission 26*, pp 1, 7, 19–23; War Widows' Guild of Australia, *Submission 28*, p. 1; Soldier On, *Submission 29*, p. 3; Phoenix Australia, *Submission 30*, pp 8–9; Aspen Medical, *Submission 38*, pp 76–77; Legacy Australia, *Submission 39*, pp 1–4; Alliance of Defence Service Organisations, *Submission 40*, pp 2–4; Partners of Veterans Association of Australia, *Submission 42*, pp 1–7; Name withheld, *Submission 43*, pp. 1–3; Name withheld, *Submission 44*, pp 1–6; Miss Alanna Powers, *Submission 48*, p. 1; Slater & Gordon Lawyers, *Submission 51*, pp 17–18; Royal Australian Armoured Corps Corporation, *Submission 59*, pp. 2–3; Dr Kevin Kraushaar, *Submission 64*, p. 9; Mrs Catherine Lawler, *Submission 66*, p. 4; KCI Lawyers, *Submission 71*, p. 3; Australian Association of Social Workers, *Submission 77*, p. 2.

60 War Widows' Guild of Australia, *Submission 28*, p. 1.

2.53 The committee received evidence from ADF members' and veterans' partners, describing their experiences living with and supporting partners struggling with mental ill health.⁶¹ Miss Alanna Power detailed her experiences supporting her partner Mr Ryan Geddes, during an incident in which he was engaging in dangerous self-harm:

Ryan [her partner] was deployed to Afghanistan as a combat engineer in 2010 on MTF1 and again in 2011 in a non-combat role...As a combat engineer, Ryan experienced many traumatic events, some of which I know he will probably never tell me about. In 2014 he was diagnosed with PTSD, anxiety and depression, although his first symptoms appeared in early 2012...Some of the symptoms that Ryan experiences include major anxiety about being in public or meeting new people, hypervigilance, night terrors, self harming, serious depressive episodes, anger control issues, lack of empathy and the inability to sleep without medication.

In October 2014 I came home from work to find Ryan with a large hunting knife engaging in a serious self harming incident. I was on my own and could not get the knife off him and so the police and paramedics were called to diffuse the situation. The knife was only handed over once the police pepper sprayed Ryan in the face...I was informed by the hospital that Ryan was in a dissociative state when he was self harming. This episode was triggered by the air conditioning blowing up in Ryan's car while he was driving. Essentially he was transported back to a traumatic event which occurred in Afghanistan.⁶²

2.54 Mr Geddes told the committee of his struggle identifying his mental illness due to the pressure and stigma associated with mental ill-health as well as the impact that this had on Miss Powers:

I knew that there was something wrong. I did not know what it was. I was angry. I was drinking a lot, and I was taking a lot of it out on Alanna. Yes, I did know that there was something there, but I did not want to admit to it...It was a weakness, and up until early this year I still thought of it as a weakness. Until all my friends told me, my partner told me, my parents told me, and I just told them to get you know, that I was fine. I did not want to process; I did not want to go through that way because I wanted to still be able to work. I thought if I do say anything about this, then that is me, I am never going to be able to get a job doing what I want to do again.⁶³

2.55 Mrs Catherine Lawler told the committee about her experience supporting her husband, Mr John Lawler, describing herself as 'worn out and worn down' and 'angry too'. Mrs Lawler explained that she disengaged emotionally from her husband to cope

61 For example: Returned and Services League of Australia, *Submission 19*, pp. 34–36; Partners of Veterans Association of Australia, *Submission 42*, pp 9–10; Name withheld, *Submission 43*, pp. 1–3; Name withheld, *Submission 44*, pp 1–6; Miss Alanna Powers, *Submission 48*, p. 1; Mrs Catherine Lawler, *Submission 66*, p. 4.

62 Miss Alanna Powers, *Submission 48*, p. 1.

63 Mr Ryan Geddes, *Committee Hansard*, 31 August 2015, p. 69.

with the situation and even contemplated suicide to 'stop [herself] from sharing his pain':

John has withdrawn from involvement in the day to day tasks of our domestic lives, and I undertake all household chores, inside and outside the house, and financial dealings. I generally liaise with doctors, government departments, his RSL advocate, etc. on John's behalf. We will often go for long periods where I also do all of the driving. All of this has had an impact on my physical health, and I am constantly fatigued. I have gradually withdrawn from the workforce to be John's fulltime carer.

The anger and rage that engulfed John increased the tension between us to unbearable levels. I tried to be supportive, I tried to understand, but I was struggling. I was worn out and worn down. There were many times when I was angry too. I know I could not be his wife and his psychiatrist too.

I found myself in a position where the best thing to do was disengage from John, go about my daily business and pretend I did not care. But I did care, and his pain was my pain. I eventually found myself thinking that if I killed myself I could stop myself from sharing his pain. But I couldn't kill myself because I knew my family would never forgive him. Then I realised that if I was to drive my car into a tree no-one would know it was deliberate...⁶⁴

2.56 The Vietnam Veterans' Federation of Australia asserted that the children of Vietnam veterans 'have had a 300 per cent higher suicide rate than their equivalents in the general community, a statistic resulting from veterans' families becoming dysfunctional because of veteran fathers' war caused psychological illnesses'.⁶⁵

2.57 Recent research into suicidality in Australian Vietnam veterans and their partners found that relative risks for suicidal ideation, planning, and attempts were 6.2, 3.5 and 6.0 times higher for partners of Australian Vietnam veterans compared with the Australian population.⁶⁶

Significance and impact of mental ill-health

2.58 The committee received considerable evidence from individuals sharing their experiences with mental ill-health and the enormous impact that it has had on their career, families, and overall quality of life.⁶⁷ Phoenix Australia outlined the enormity of the impact on the individual's quality of life and on society more broadly:

64 Mrs Catherine Lawler, *Submission 66*, p. 4.

65 Vietnam Veterans' Federation of Australia, *Supplementary Submission 2.2*, Attachment 2, p. 1.

66 Brian O'Toole, *et al.*, 'Suicidality in Australian Vietnam veterans and their partners', *Journal of Psychiatric Research*, vol. 65, June 2015, p. 30.

67 For example: Mr Douglas Steely, *Submission 6*; Name withheld, *Submission 8*; Mr Dennis Lee, *Submission 9*; Mr Roy Seal, *Submission 11*; Name withheld, *Submission 13*; Mr Jayden Moseley, *Submission 31*; Name withheld, *Submission 36*; Name withheld, *Submission 43*; Name withheld, *Submission 44*; Miss Alanna Power, *Submission 48*; Name withheld, *Submission 57*; Mr John Lawler, *Submission 58*; Mr Dennis Crouch, *Submission 60*; Mrs Catherine Lawler, *Submission 66*; Name withheld, *Submission 67*; Mr Dennis Bass, *Submission 69*; Name withheld, *Submission 70*; and Name withheld, *Submission 79*.

A large body of data attests to the substantial functional impairment and reduced quality of life associated with mental health diagnosis. That is, these disorders substantially impair the person's ability to function in social relationships, including with partners, children, friends, and other loved ones. Rates of separation and divorce are high. Mental health disorders impair the person's ability to function in their normal role (e.g., in employment, study, or parenting).

...veterans with mental health problems showed higher rates of unemployment, social dysfunction, marital separation, reduced engagement with productive activity and poorer quality of life...The number of disability and incapacity claims associated with mental health problems that are accepted by DVA is further testament to the impairment associated with these conditions.

The human cost in terms of distress, poor quality of life, family breakdown, and suicide, as well as the financial costs in terms of lost productivity, health care, and benefits, are enormous.⁶⁸

2.59 The significance of mental health on ADF members and veterans was also highlighted by KCI Lawyers, which specialise in assisting veterans seeking compensation, which noted that:

The significance of psychological conditions is substantial given the effects on the Veterans' capacity to not only remain in the ADF, but to function at a reasonable level within the Defence community and to coexist harmoniously with their family, with their peers and friends. Their ability to find and maintain civilian employment is also a major issue for those suffering from PTSD.

Unlike a 'physical' injury that, at least can be explained and the impact self-evident, PTSD is devastating to the individual with respect to their self-esteem, motivation and outlook on life. A Veteran cannot simply 'explain' why they are unable to work, or spend large amounts of time in relative isolation and medicated to treat and intangible condition. Their sense of self-worth is degraded, their relationship with their spouses or partners suffers, often irreparably, their confidence to deal with their families, friends, peers and strangers gradually erodes.⁶⁹

2.60 One submitter told the committee of their experience with PTSD and Depression and its impact on their life following medical discharge for mental ill-health. The individual told the committee of the profound impact that mental ill-health has had on their relationships with family and friends and explained its impact on their ability to live and function in society, highlighting the compounding nature of the impacts of mental ill-health and their feelings of hopelessness and despair:

You see when you suffer from mental illness you become like a deer in headlights. Anxiety and stress sinks in and seemingly simple tasks become complex and distressing.

68 Phoenix Australia, *Submission 30*, p. 4.

69 KCI Lawyers, *Submission 71*, pp 2–3.

At this time my relationship with my parents began to break down. My behaviour was erratic and I also become involved in alcohol related incidents in town. This is not good in a small country town and before things got out of hand, I moved to my grandmother's house on the South Coast...unfortunately my behaviour in civvy street had not improved...my time at my Grandmother's had deteriorated along the same lines as they had with my parents.

Poor behaviour and confrontations with friends and family made my time there untenable. This was particularly distressing for me; as for my entire life I'd had an extremely close relationship with my grandmother. There was only one option and that was for me to leave. I had nowhere else to go. I was burning bridges wherever I went leaving a trail of anger and resentment. I had to be away from everyone for their sake and my own.

I was in a very dark place. I had very little money, I'd ostracized myself from all my family and friends, I had no one to turn to. I'd hit rock bottom. I literally went bush and went through the worst period of my life. I hated everyone and I hated myself and I was just on my own having nightmarish conversations with myself. I was broke, any claim outcome was at least 3 more months away but it didn't matter. I wasn't going to make it.⁷⁰

Committee view

2.61 The committee expresses its deep respect for those Australians who serve and protect our country, putting their life, as well as their physical and mental health, on the line. The committee commends Defence and DVA's ongoing commitment to improve the understanding of the prevalence of mental ill-health and the impact that ADF service can have on the mental health of its members and veterans. The committee acknowledges the unique stressors of ADF service. During their service, ADF members must manage various day-to-day stressors including significant periods of time away from home, family, and friends in addition to the increased risk of exposure to potentially traumatic experiences.

2.62 The committee notes the difficulty of clearly differentiating between traumas experienced during ADF service and traumas experienced in ADF members' private lives, and that for clear conclusions to be drawn regarding the impact of ADF service 'traumas experienced during military service and in the private lives of ADF members need to be separated'.⁷¹ To this end, the committee supports the Transition and Wellbeing Research Programme and looks forward to the publication of its findings.

2.63 The committee also appreciates that mental ill-health in veterans will often go unrecognised and undiagnosed many years after leaving the ADF. This creates real challenges for policy makers and mental health practitioners who are focusing on strategies for the early detection and treatment of mental ill-health.

70 Name withheld, *Submission 79*, p. 2.

71 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 51.

2.64 The committee understands that DVA is limited in its ability to measure the prevalence of mental ill-health in veterans to those veterans who have sought assistance or made a claim with DVA. The committee notes that the number of veterans who have made claims may represent only a small proportion of those veterans who have or are struggling with mental ill-health. The Transition and Wellbeing Research Programme will provide invaluable data regarding the prevalence of mental health in veterans as well as highlighting which areas still need to be investigated.

Suicide

2.65 Since 2000, more than 100 ADF members are suspected or have been confirmed to have died as a result of suicide. It is a terrible tragedy whenever any ADF member loses their life during their service; however, when a member dies as a result of suicide it is particularly devastating for the family, friends, and colleagues of the deceased member.

2.66 A number of submissions called for the introduction of a government maintained public record of ADF members and veterans who have died as a result of suicide. The committee agrees that accurate data regarding the rate of suicide among ADF members and veterans is an important element of addressing suicidality and formulating policy to address it. The committee has carefully weighed the arguments in favour of a public record of ADF members and veterans who have died as a result of suicide against the risk to ADF members', veterans', and their families' right to privacy. On balance, the committee is not in favour of recommending the creation of a public record of ADF members and veterans who have died as a result of suicide.

2.67 The committee is satisfied that current pathways for scrutinising the deaths of ADF members, and (through civilian pathways) veterans, are adequate. Defence currently records the death of members during their service, including those suspected or confirmed to have died as a result of suicide. It is much more difficult, however, to determine the number of veterans who have died as a result of suicide. The committee notes that DVA has commissioned studies from the Australian Institute of Health and Welfare and the Australian Institute for Suicide Research and Prevention to investigate the prevalence of suicide among veterans. The committee looks forward to the publication of its findings.

