

# Chapter 4

## Mental health services

### Introduction

4.1 This chapter considers the diagnosis and treatment of mental ill-health and the adequacy of mental health support services provided to ADF members and veterans and their families.

### Diagnosis and treatment of mental illness

4.2 The committee received a number of submissions commenting on the treatment and diagnosis of mental ill-health.<sup>1</sup> Phoenix Australia acknowledged that it is difficult to evaluate the quality and commitment to evidence-based mental health services delivered by external providers, but stressed the importance of evaluation of the quality of care:

If we are serious about ensuring that past and present Defence Force members get the best possible care...the evaluation of the quality and outcomes of contracted work across private clinical service facilities and private practitioners is a challenge that we must continue to try to address. This would also include the evaluation of the utilisation by practitioners and services of available referral options and pathways to maximise the matching levels of need to level of care.<sup>2</sup>

4.3 The Returned & Services League of Australia (RSL) stated that 'there is an urgent need to learn more about PTSD and its related mental health problems and to develop new and effective treatments'. The RSL told the committee that 'the best treatments currently available only work for some and only a third of PTSD patients fully recover', calling for 'systemic research' to address the gaps in the understanding of PTSD, test innovative treatments, and discover how to improve treatment effectiveness.<sup>3</sup>

4.4 Veterans' Health Advisory Council (South Australia) acknowledged the importance of evidence-based care, but noted that evidence-based care guidelines developed for the civilian population may not meet the specific needs of ADF members and veterans. The Council warned that an overreliance on civilian evidence-based care guidelines can have the unintended consequence of limiting service provision:

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1 For example: Dr Jerome Gelb, *Submission 5*; Mr Brian McCarthy, *Submission 20*; Australian Psychological Society, *Submission 22*; Phoenix Australia, *Submission 30*; Dr Niall McLaren, *Submission 50*; Major Stuart McCarthy, *Submission 54*; Mr Greg Hogan, *Submission 61*; Ms Christine Perry, *Submission 63*; Dr Kevin Kraushaar, *Submission 64*; Mr Derek Sheppard, *Submission 68*.

2 Phoenix Australia, *Submission 30*, p. 7.

3 Returned & Services League of Australia, *Submission 19*, p. 9.

...there has been an increasing constriction of the services that will be reimbursed through these facilities with the reasonable justification of the application of treatment guidelines and evidence-based care. However, it is important to realise that treatment guidelines have become an instrument of managed care that may have the unintended consequence of limiting service provision. Evidence-based care has significant limitations in the field of veteran mental health because treatments, used in civilian facilities, are often developed on clinical populations who specifically frequently exclude those with characteristics and comorbidities typical of veterans. To highlight this disparity, there is significant and growing evidence that psychological treatments for PTSD in veterans have worse outcomes than in civilian population groups. Treatment guidelines developed from non-veteran populations therefore have significant limitations on veteran's health care, particularly in relation to informing the care of veterans with chronic disorders who have not responded to the mainstream first line therapies.<sup>4</sup>

4.5 The Council also criticised DVA's move away from veteran-specific hospitals and the subsequent loss of specialist staff in a range of medical and allied health fields that 'consolidated and represented generations of expertise in the care of veterans'.<sup>5</sup>

### ***Neurological problems***

4.6 A number of submissions commented on the importance of recognising that mental ill-health can be caused by neurological issues (structural, biochemical, or electrical abnormalities in the brain). Major Stuart McCarthy told the committee that, despite advances in neurological science in treatment and rehabilitation, insufficient emphasis is given to neurology as a causative factor of mental ill-health and that medical practitioners are reluctant to investigate neurological causes for what appear to be psychiatric or psychological problems:

...there has been a growing awareness of physical injuries as causes of neurological damage, with symptoms including cognitive impairment, for example blast causing TBI...Advances in neurological science in *treatment* and rehabilitation for physical injuries have been prominent, however insufficient emphasis is given to neurology as a causative factor. Despite these advances, many veterans experience problems in seeking appropriate diagnosis, treatment and support for more complex neuro-psychiatric injuries or illnesses due to a reluctance by medical practitioners to investigate neurological causes for ostensibly "psychiatric" or "psychological" problems. Neurological symptoms are often initially dismissed as "psychological".<sup>6</sup>

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4 Veterans' Health Advisory Council (South Australia), *Submission 55*, p. 2.

5 Veterans' Health Advisory Council (South Australia), *Submission 55*, p. 1.

6 Major Stuart McCarthy, *Submission 54*, p. 2.

### *Traumatic Brain Injuries*

4.7 A number of submitters asserted that Traumatic Brain Injuries (TBIs), also referred to as Post-Concussion Syndrome (PCS), should be recognised as a possible cause or contributing factor when diagnosing and treating ADF members' and veterans' symptoms of mental ill-health.<sup>7</sup> The Alliance of Defence Service Organisations explained that the symptoms of TBI can be very similar to the symptoms of PTSD and that incorrect diagnosis can lead to poor outcomes:

...symptoms [of PCS] which remained largely undetected until they had actually returned home and began to manifest themselves when veterans started having difficulty in functioning as efficiently as they had prior to deployment...this begs the question whether PCS is masking symptoms of PTSD or vice versa and possibly confusing the nature of treatment regimes and rehabilitation programmes. Such a crossover of symptoms plus the delayed effect reported by Zeitzer *et al*, along with any potential masking effects could have the potential to adversely affect and complicate the successful condition-focussed rehabilitation of injured service personnel who have suffered a close traumatic brain injury or PTSD.<sup>8</sup>

4.8 Defence advised the committee that it has 'specific policies in place' for the care and management of patients with PTSD and TBI. DVA assured the committee that it is aware of emerging issues regarding TBI and its impact on mental health, noting that 'mild traumatic brain injury has come under increasing attention by military medicine' and that its 'symptoms may mask PTSD'.<sup>9</sup>

### *Mefloquine neurotoxicity*

4.9 The committee received evidence regarding the neuro-psychiatric effects of mefloquine hydrochloride (mefloquine)<sup>10</sup>, an anti-malarial drug used to prevent and treat certain forms of malaria. Major McCarthy informed the committee that there is extensive research providing evidence that quinolones, including mefloquine, can cause brain injuries that result in neuropsychiatric symptoms.<sup>11</sup> Dr Jane Quinn explained that:

The parts of the brain that it works on are the areas of the brain that are affected in the chronic disease state caused by mefloquine toxicity, which can be described as a limbic encephalopathy, with vestibulopathy—if you will pardon the long terms. That basically translates to a disorder of the part of the brain that governs anxiety, fear and normal cognitive processing, associated with the part of the brain that deals with balance. A majority of

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7 For example: Returned & Services League of Australia, *Submission 19*, pp 4, 16; Aspen Medical, *Submission 38*, p. 87; Alliance of Defence Service Organisations, *Submission 40*, pp 8–9; Major Stuart McCarthy, *Submission 54*, p. 2; Mr Greg Hogan, *Submission 61*, p. 6–7, 13.

8 Alliance of Defence Service Organisations, *Submission 40*, pp 8–9.

9 Department of Veterans' Affairs, *Submission 35*, p. 21.

10 Note that Mefloquine is also known by its trade name Lariam.

11 Major Stuart McCarthy, *Submission 54*, p. 3.

symptoms that have been presented in long-term chronically affected individuals are rage, extreme anxiety, paranoia, auditory or visual hallucinations, vestibular disorder—balance disorders, tinnitus. In a military setting, a lot of those kinds of neuropsychiatric side effects really cross-reference very closely with those that present in PTSD, for example. There has been some concern in the medical profession that there is a subset of individuals whose clinical symptoms of PTSD are exacerbated by having taken mefloquine or that their disease state is actually caused by the drug they have taken and not by classic PTSD at all. It is a very complex neurological condition. It has only been well-characterised in the medical literature in the past eight years, I would say, but it is now well-characterised, and a diagnosis can be made.<sup>12</sup>

4.10 In 2013, the United States Food and Drug Administration gave mefloquine its strictest warning, known as a black box warning, 'due to risk of serious psychiatric and nerve side effects.'<sup>13</sup> Major McCarthy told the committee that, following the issue of the black box warning, the commander of US Army Special Operations Command ordered that mefloquine no longer be used. Furthermore, Major McCarthy noted that US members exhibiting symptoms of toxicity undergo medical assessment and that mefloquine is listed on the US Department of Veterans' Affairs 'deployment exposures' website.<sup>14</sup>

4.11 Major McCarthy called for the introduction of a mefloquine veterans outreach program. The program would include identifying all ADF members administered mefloquine during their service; funding further research regarding mefloquine toxicity; raising awareness and education regarding mefloquine toxicity; training health staff in the diagnosis, treatment, rehabilitation of mefloquine toxicity; and providing social support for veterans and their families. Major McCarthy also called for a 'full, independent inquiry into mefloquine use in the ADF and its impact on veterans and their families, including the conduct of clinical trials by the [Army Malaria Institute], the involvement of the manufacturer, decisions by senior ADF leadership and the involvement of foreign governments and organisations'.<sup>15</sup>

4.12 Defence advised the committee that mefloquine is one of three anti-malarial medications approved by the Therapeutic Goods Administration (TGA) for malaria prevention in our region and that 'it is Defence's third line agent, meaning it is only used when one of the other two medications is not appropriate'. Defence assured the

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12 Dr Jane Quinn, *Committee Hansard*, 1 September 2015, p. 46.

13 United States of America Food and Drug Administration, *FDA Drug Safety Communication: FDA approves label changes for antimalarial drug mefloquine hydrochloride due to risk of serious psychiatric and nerve side effects* <http://www.fda.gov/Drugs/DrugSafety/ucm362227.htm>, accessed 5 February 2016.

14 Major Stuart McCarthy, *Submission 54*, p. 4.

15 Major Stuart McCarthy, *Submission 54*, p. 8.

committee that mefloquine 'is only prescribed in accordance with TGA approved product information and Defence health policy'.<sup>16</sup>

4.13 Defence acknowledged that both short-term and long-term side-effects can result from mefloquine use and that those suffering from these side-effects can claim compensation:

While in the majority of cases the side-effects associated with mefloquine disappear after ceasing the medication, Defence accepts that some people do continue to experience on-going issues. Those who claim to have ongoing problems linked to side-effects from the use of mefloquine are provided with appropriate medical treatment including specialist referral, assessment and treatment. Further to this ADF members who are diagnosed as suffering longer term or permanent side-effects from mefloquine use can also claim compensation through the Department of Veterans Affairs (DVA) if the mefloquine was prescribed for service reasons.<sup>17</sup>

4.14 Defence noted that the 'vast majority of ADF members have never been prescribed mefloquine', with an average of 25 members per year 'who demonstrated such intolerance to other anti-malarial medication as to warrant being prescribed mefloquine'. Defence stated that 'less than one per cent of ADF members currently deployed and receiving anti-malarials are taking mefloquine' and that 'within Defence mefloquine is prescribed at a significantly lower rate than in the general community'.<sup>18</sup>

### ***Moral injury***

4.15 Some submissions highlighted the impact of 'moral injury' on ADF members' and veterans' mental health.<sup>19</sup> Professor Thomas Frame explained that moral injury results from an 'existential dissonance', where there is a sharp disagreement between what a person believes to be morally right and what they, or others, have experienced or done:

There is a consensus emerging that moral injury is associated with the disturbance, disruption or diminishment of a uniformed person's moral outlook and the depletion, degradation or disorientation of their inner moral compass as a consequence of operational service, be it warlike or non-warlike. It is plainly not synonymous with PTSD.

The incidence of moral injury is not predicated on a traumatic experience. A traumatic event may cause moral injury, but a person can be morally injured, an injury perhaps manifest in personal guilt and shame, whether justified or not, or indifference, perhaps, to human pain and suffering

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16 Department of Defence, 'Statement on the use of mefloquine in the ADF', Media release, 30 November 2015.

17 Department of Defence, 'Statement on the use of mefloquine in the ADF', Media release, 30 November 2015.

18 Department of Defence, 'Statement on the use of mefloquine in the ADF', Media release, 30 November 2015.

19 For example: Mr Mark Keynes, *Submission 10*, p. 1; Major Stuart McCarthy, *Submission 54*, pp 6–7.

without the causal event itself being traumatic. Moral injury does not flow from external stress but from internal reflection. It has to do with what a person themselves makes of what they see, hear, smell, touch and taste while on deployment.

While operational service might impose an inordinate number of physical and mental demands and be the cause of intense stress, moral injury arises from existential dissonance associated with comparing idealised conceptions to concrete realities. In other words, there is a sharp disagreement about how things should be and how they actually are. So, in reflecting upon a morally challenging experience, a morally injured person realises they were not the individual they had previously believed themselves to be or hoped they were. This realisation, 'I am not the person I thought I was', causes discomfort and even despair.<sup>20</sup>

4.16 Professor Frame also described the impact of moral injury:

The morally injured person can be debilitated by their injuries in a number of ways. He or she could abandon notions of right and wrong, good and bad, as they inhabit a world in which only legality defines morality. So a morally injured person could become completely hostile to all forms of authority and suspicious of every institution exercising any kind of power. The morally injured could be paralysed by unremitting guilt and unrelieved shame with no creative or constructive forms of confession and absolution, forgiveness and reconciliation.<sup>21</sup>

4.17 Major McCarthy noted that moral injury wounds members' and veterans' moral character as well as destroying their capacity for social trust, where social trust is defined as 'the expectation that power will be used in accordance with "what's right"'. This significantly impacts the ADF member or veteran's treatment, as the key resource for successful psychological treatment, trust, has been destroyed:

...the significance of moral injury should now be clear, especially the *lack of trust* experienced by veterans as a result of their ADF service. Actions by authorities that destroy trust either during or subsequent to operational service can be a *cause* of psychological injuries. Lack of trust can be a key *symptom* of neuro-psychiatric illnesses, including those caused by TBI and neurotoxic drugs such as mefloquine. And a lack of trust can be a major barrier that *prevents* veterans receiving effective care.<sup>22</sup>

4.18 The Veterans Care Association called for a greater emphasis to be placed on pastoral care when addressing and maintaining the mental health of ADF members and veterans questioning their identity to address feelings of guilt:

The current paradigm of relying primarily on pharmaceutical medication and counselling is treating illness, but not addressing the "soul issues" of hope, identity and future purpose. The Chaplain or peer pastoral carer is

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20 Professor Thomas Frame, *Committee Hansard*, 31 August 2015, p. 59.

21 Professor Thomas Frame, *Committee Hansard*, 31 August 2015, p. 60.

22 Major Stuart McCarthy, Submission 54, p. 6.

able to assure the veteran of confidential treatment of their insecurities, their need to address guilt and reconciliation if needed, as well as help them to imagine new possibilities of life beyond their distress, or how to confront death with dignity.<sup>23</sup>

4.19 The Vice Chief of the Defence Force, Vice Admiral Ray Griggs AO CSC, advised the committee that Defence is working to better understand and address concerns regarding moral injury, with the first element of this being a scoping study with Professor Frame.<sup>24</sup>

### ***Use of pharmaceuticals and electroconvulsive therapy***

4.20 The committee received evidence from Dr Niall McLaren, a psychiatrist whose long career has focused on treating veterans. Dr McLaren advised the committee that standard psychiatric management of PTSD 'relies heavily on large doses of powerful medication in the very long term, coupled with extensive psychological counselling of various types' and that electroconvulsive therapy (ECT) is viewed by many psychiatrists as 'a useful and essential treatment option'.<sup>25</sup>

4.21 Dr McLaren advised the committee that he treats veterans as outpatients, with a minimum of drugs and never uses ECT, noting that his 'results are at least as good as if not better than the standard results'.<sup>26</sup> Dr McLaren called for the ADF to conduct an audit of private psychologists to determine value for money in terms of treatments used and outcomes for veterans:

The ADF does not audit private psychiatrists who manage the great bulk of veterans. There is no comparison of outcomes, no comparison of costs, no attempt to ask people to present their results or methods, no effort to explore options. The ADF absorbs massive costs without demur—\$100,000 at hospital admission, which in my experience is a complete waste of money. The actual costs are a closely held secret. Truly outrageous cost claims are submitted and paid with no questions asked. There are a lot of private psychiatrists making a great deal of money from ADF members and veterans, but the prevailing attitude seems to be that as long as something is being seen to be done everybody is off the hook. CYA—cover your arse—seems to be the prevailing ethos: heavily sedated unemployable patients who are in and out of hospital and rarely complain too much, but when something goes wrong, like a suicide, everybody can stand around and say: 'Well, we did our best. Look how much we spent.'

4.22 Dr McLaren told the committee that treatment focused on the standard methods, involving the use of powerful medications, is expensive and ineffective, noting that 'people who embark on the standard type of program generally do not

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23 Veterans Care Association, *Submission 4*, p. 2.

24 Vice Admiral Ray Griggs AO CSC, Vice Chief of the Defence Force, *Committee Hansard*, 21 September 2015, p. 11.

25 Dr Niall McLaren, *Submission 50*, p. 5.

26 Dr Niall McLaren, *Committee Hansard*, 1 September 2015, p. 34.

return to work'. Dr McLaren advised the committee that, in his experience, ECT was also very expensive but 'neither useful nor essential'.<sup>27</sup>

4.23 The committee also received submissions highlighting alternative treatments for mental ill-health including utilising emotional freedom techniques and Ayurvedic techniques (traditional medicine from India).<sup>28</sup>

### **Mental health services available to ADF members**

4.24 Generally, submissions agreed that, provided ADF members were willing to seek treatment, access to mental health services were adequate.<sup>29</sup> Phoenix Australia commended the ADF for its 'considerable' and 'substantial progress with regards to the provision of mental health services for its members, noting that if a member voluntarily presents to Garrison Health or an ADF health facility for help regarding mental ill-health, 'there are policies and procedures in place which should ensure that the person is assessed and provided with appropriate treatment by an ADF mental health professional or an externally contracted provider'.<sup>30</sup>

4.25 Phoenix Australia noted that there 'remain gaps between routine care and best practice in parts', but commented, 'it is worth noting that range and quality of services available to current and past members of the Defence Force are generally better than those available for citizens and other emergency personnel'.<sup>31</sup> Phoenix Australia commended Defence for 'the commitment shown by the ADF to evaluation of their mental health programs, with a particular focus on quality improvement. This is not an easy area, but it is fundamental to ensuring that the programs are of optimum quality and value, and that they are being delivered as intended'.<sup>32</sup>

4.26 Some submitters did note that the quality of service was dependant on where ADF members were based.<sup>33</sup> One submitter commented that:

The mental health treatment services available to ADF personnel vary according to location...there are centres where there is ready access with providers who are experienced in treating ADF personnel and who have experience with the ADF Medical Classification System. There are other locations where services are piecemeal and external referral is the norm.<sup>34</sup>

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27 Dr Niall McLaren, *Submission 50*, p. 5.

28 Ms Christine Perry, *Submission 63*, pp 1–3; Mr Derek Sheppard, *Submission 68*, p. 1; and Mr Donald Sullivan, *Submission 32*, pp 1–31.

29 For example: Walking Wounded, *Submission 18*, p. 3; Mr Jeremy Davey, *Submission 25*, p. 3; Phoenix Australia, *Submission 30*, pp 6–7; Aspen Medical, *Submission 38*, p. 85; Alliance of Defence Service Organisations, *Submission 40*, p. 2.

30 Phoenix Australia, *Submission 30*, pp 6–7.

31 Phoenix Australia, *Submission 30*, pp 6–7.

32 Phoenix Australia, *Submission 30*, p. 6.

33 For example: Returned & Services League of Australia, *Submission 19*, p. 8; Australian Psychological Society, *Submission 22*, p. 10; Name withheld, *Submission 56*, p. 2.

34 Name withheld, *Submission 56*, p. 3.



4.27 The Royal Australian Regiment Association commented on the removal of medical officers from regular army battalions in 2011, noting that this has impacted on the continuity of care received by soldiers and consequently the quality of care:

This has meant that an infantry soldier reporting to an area medical centre is likely to be seen by a different doctor each time he reports. On deployment, a doctor who will not be familiar with the battalion will be attached. All Commanding Officers were and still are opposed to this loss of capability, but their objections appear to be falling on deaf ears.

The lack of an RMO who knows the soldiers of the Battalion is a major impediment to identify mental health issues and early intervention for PTSD in particular in the members of the Battalion and with early intervention of PTSD being a key issue in the management and treating of the condition the lack of a permanent RMO is a major mistake which must be rectified.<sup>35</sup>

4.28 Aspen Medical reported that its partitioners felt that 'JHC provides high quality Mental Health Care to ADF members including [members who have been deployed] suffering deployment related mental health conditions', but noted that issues tend to arise when more than one agency is involved in the delivery of care to ADF members with mental health conditions:

For example there are coordination issues between:

- i. Garrison and Theatre – this particularly affects the ability of MO and MHP to readily access records that were made in theatre. This stems from the obvious limitations to record keeping in the middle of a battlefield where exposure to a traumatic event often occurs;
- ii. On-base and Off-base – there was a consensus view that on-base health professionals had a greater familiarity with relevant policy than off-base clinicians. They also better understood the context of military medicine and mental care better than their off-base counterparts;
- iii. Clinical and Command – the transition between clinical care and ongoing care in the unit setting can be complex to manage. There was a general view amongst respondents that unit commanders don't fully appreciate or understand the role of the MP and MHP in delivering mental health care to their unit members; and
- iv. Defence and non-Defence – this is particularly evident in the transition out process where a veteran transitions to become the responsibility of the Department of Veterans' Affairs (DVA). The respondents felt that there are opportunities to improve the transition out process.<sup>36</sup>

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35 Royal Australian Regiment Association, *Submission 46*, pp 6–7.

36 Aspen Medical, *Submission 38*, p. 85.

4.29 The Veterans' Health Advisory Council (South Australia) highlighted the importance of clinical expertise and leadership in the provision of mental health services to military personnel, criticising Defence for using a 'purchaser-provider model', which 'assumes that the clinical expertise exists within the broader community' and for its lack of uniformed psychiatrists:

In addition to the devolution of health services and expertise in Australia, specifically in the field of mental health, Australia is faced with the additional challenge of informing, coordinating and delivering mental health care services without any full-time uniform psychiatrists, which is unlike any other Defence Force of equivalent size nations, particularly our NATO allies. It is only in the last 3 years that an APS psychiatrist has been employed in the ADF...Instead of drawing on veteran specific expertise in various medical disciplines, the Defence Force has depended on the specialists reserves, who primarily treat civilians, for the equivalent capacity.<sup>37</sup>

4.30 Defence told the committee that early identification of mental ill-health and access to treatment and rehabilitation for mental health issues are key priorities. Defence advised the committee that mental health, psychology, and rehabilitation services are provided to ADF members 'as an integral component of the overall Defence primary health care system' and that Defence 'is committed to continuous improvements to health services'.<sup>38</sup>

4.31 Defence advised that the delivery of mental health and psychology services is a 'multi-tiered responsibility' with:

- Garrison Health Operations providing the strategic planning and coordination of the regional health services;
- ADF Centre for Mental Health providing a national operational level for workforce training and the management of programs;
- Regional Mental Health Teams providing the regional operational level by delivering clinical supervision to service providers and coordinating services for the Joint Health Units, and the Mental Health and Psychology Sections at the tactical level providing local health services to ADF personnel.<sup>39</sup>

4.32 Defence informed the committee that it has strengthened its mental health workforce, creating 91 new positions:

- 74 new positions for regional and local service delivery (34 Australian Public Service (APS) and 40 contracted providers);
- seven new positions at the ADF Centre for Mental Health (four ADF, two APS and one contracted psychiatrist); and

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37 Veterans' Health Advisory Council (South Australia), *Submission 55*, p. 3.

38 Department of Defence, *Submission 34*, p. 11.

39 Department of Defence, *Submission 34*, pp 11.

- 10 new positions for policy and program development (one Senior Executive Service (SES) Level 1 and nine APS).<sup>40</sup>

4.33 Defence advised that its mental health and psychology services are delivered by a wide range of health professionals including uniformed medical officers and mental health professionals from the Army, Navy and Airforce.<sup>41</sup> Defence noted that it has access to an additional 1,846 mental health service providers (266 psychiatrists and 1,580 psychologists) under the Medibank Health Solutions contract.<sup>42</sup>

4.34 Defence informed the committee that it delivers a range of mental health and psychology programs and training for ADF members, including:

- ADF Alcohol, Tobacco and Other Drugs Program;
- ADF Suicide Prevention Program;
- Keep Your Mates Safe – Peer Support Network, which is intended to address stigma, increase awareness of support services and provide practical mental health first aid skills; and
- BattleSMART, which is a preventative program designed to enhance an individual's ability to cope effectively with increased stress and adverse or potentially traumatic events.<sup>43</sup>

4.35 Defence advised that its delivery of mental health, psychology, and rehabilitation support services is enhanced by a number of general awareness and promotion resources and activities including:

- topical fact sheets;
- Mental Health Online: webpage containing information and links to online mental health resources for ADF members and their families and 'At Ease' website;
- Defence helplines (All-Hours Support Line, '1800 IM SICK', and Defence Family Helpline);
- ADF Mental Health Day;
- mobile apps developed in conjunction with DVA, including:
  - On Track with the Right Mix, which assists individuals to monitor and manage alcohol consumption;
  - PTSD Coach Australia, which assists individuals to learn about and manage symptoms that commonly occur after trauma;

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40 Department of Defence, *Submission 34*, pp 3-4.

41 Department of Defence, *Submission 34*, pp 11.

42 Department of Defence, *Submission 34*, pp 3-4.

43 Department of Defence, *Submission 34*, p. 13.

- High Res App, which assists individuals to build resilience and manage their response to stress, and High Res Website, which assists individuals to manage stress and improve resilience, providing a Self-Management and Resilience Training (SMART) toolbox that complements the app; and
- Operation Life, which assists who are at risk of suicide, in addition to providing a guide for clinicians;<sup>44</sup> and
- mobile apps from third parties, including:
  - Tactical Breather (United States of America Department of Defence): assists individuals to gain control over physiological and psychological responses to stress;
  - Breathe2Relax (United States of America Department of Defence): provides individuals with information on stress management and the effects of stress on the body;
  - My Compass: (Black Dog Institute): provides an interactive self-help service to promote resilience and wellbeing;
  - MindHealthConnect Online Apps Library: provides resources from leading health-focused organisations in Australia;
  - MoodGYM (Australian National University): assists individuals develop skills for preventing and coping with depression; and
  - E-couch (Australian National University): provides individuals with interactive self-help modules for depression, anxiety, relationship breakdown, loss, and grief.<sup>45</sup>

4.36 Defence advised the committee that it has developed a Defence Mental Health Workforce Clinical Skilling Framework to ensure that the mental health care provided by Defence is aligned with community best practice and suits the ADF environment. Under the Framework all Defence mental health professionals are trained, credentialed, supervised, and supported to deliver services to ADF members. This includes upskilling in PTSD; suicide; Alcohol, Tobacco and Other Drug assessment and treatment; acute management of mental health presentation in the deployed environment; and the provision of family-sensitive practice.<sup>46</sup>

### ***Rehabilitation specific programs***

4.37 The ADF Rehabilitation Program 'aims to return ADF personnel who are injured or ill to work in Defence or to successfully medically transition to the civilian

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44 Department of Defence, *Defence Health Portal: Web and Mobile Applications*, <http://www.defence.gov.au/health/healthportal/apps.asp> accessed 2 February 2015.

45 Department of Defence, *Defence Health Portal: Web and Mobile Applications*, <http://www.defence.gov.au/health/healthportal/apps.asp> accessed 2 February 2015.

46 Department of Defence, *Submission 34*, p. 13.

environment'.<sup>47</sup> Defence advised the committee that for the period of July 2013 to June 2014 a total of 869 referrals to the ADF Rehabilitation Program were due to a primary diagnosis of a mental illness, which is 17.3 per cent of the total number of rehabilitation referrals for the period.<sup>48</sup> The rehabilitation program is enhanced by the Simpson Assistance Program and the Support to Wounded, Injured or Ill Program.

4.38 The Simpson Assistance Program comprises a series of initiatives that 'enhance the existing rehabilitation efforts by developing tailored recovery programs to support the individual needs of ADF personnel and their families'. Initiatives developed and piloted under the Simpson Assistance Program include the:

- Intensive Rehabilitation Teams;
- 'Mate-to-Mate' Peer Visitor Program;
- Meaningful Engagement Options; and the
- Living with Disability 'Families Stronger Together' residential workshop.<sup>49</sup>

4.39 The Support to Wounded, Injured or Ill Program is a joint Defence and DVA program delivered under the Memorandum of Understanding (MoU) and aims 'to facilitate the effective management of ADF members engaged in rehabilitation through a framework that considers the needs of the member and their family'. Initiatives developed under the Support to Wounded, Injured or Ill Program include:

- Soldier Recovery Centres;
- Member Support Coordinators;
- Individual Welfare Boards or Case Conferences; and the
- ADF Arts for Recovery, Resilience, Teamwork and Skills Program.<sup>50</sup>

4.40 Defence emphasised its commitment to rehabilitation. Defence informed the committee that of the 869 individuals with a mental illness who completed a rehabilitation program in the period from July 2013 to June 2014 a total of 420 (or 52 per cent) are recorded as having a successful return to work at the end of their rehabilitation program.

### ***Mental health support for deployed members***

4.41 Defence advised the committee that, in addition to the mental health services available to all ADF members, operationally-focused mental health promotion, prevention, and early treatment services are also available for deployed members. The aim of ADF Operational Mental Health Support is 'to assist ADF personnel to deploy,

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47 Department of Defence, *Submission 34*, p. 12.

48 Department of Defence, answer to question on notice, 21 September 2015 (received 23 November 2015).

49 Department of Defence, *Submission 34*, p. 12.

50 Department of Defence, *Submission 34*, pp 12–13.

perform their operational duties effectively and then return to work and private lives with minimum disruption'.<sup>51</sup>

#### *Pre-deployment*

4.42 All deploying members receive a BattleSMART mental health brief that is 'designed to enhance their ability to operate effectively in the deployment environment' and 'is tailored to meet the specific demands of the deployment'. Defence advised that the BattleSMART pre-deployment program training is delivered 'in conjunction with a comprehensive pre-deployment training package'.<sup>52</sup>

#### *During deployment*

4.43 During deployment, if deployed members are exposed to potentially traumatic events, a Critical Incident Mental Health Support (CIMHS) response is provided. The CIMHS comprises a group psycho-education brief on expected trauma reactions, coping skills, and methods of seeking support. This is followed by a targeted individual screening questionnaire and screening interview. The aim of the CIMHS is to 'identify members that require immediate intervention or scheduled follow up and facilitate a return to pre-exposure functioning'.<sup>53</sup> Deployed members in a 'high-risk' operational role that may routinely expose them to intense operational stressors, critical incidents, and/or potentially traumatic events (such as military police, explosive ordnance disposal personnel, and health personnel) are provided with a Special Psychological Screen mid-way through their deployment.<sup>54</sup>

4.44 At the end of a deployment, ideally during the week prior to leaving the operational theatre, members are provided with the Return to Australia Psychological Screen. This comprises a BattleSMART re-adjustment focused group briefing and an individual screening questionnaire and screening interview. This aims to identify members 'that may benefit from an immediate referral or early follow-up due to the deployment's impact upon their current level of psychological functioning' as well as identifying members 'who may potentially experience adjustment difficulties upon return to Australia'.<sup>55</sup>

4.45 Defence advised the committee that mental health services are also customised to meet the specific requirements of the operation. For example, Defence provides Navy crews and Transit Security Element personnel assigned to Operation RESOLUTE with a tailored program of mental health support. The program commenced in June 2011 and comprises a biennial group SMART resilience brief, annual Mental Health and Wellbeing Questionnaire, and a screening interview with a Navy psychologist.<sup>56</sup>

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51 Department of Defence, *Submission 34*, p. 14.

52 Department of Defence, *Submission 34*, p. 14.

53 Department of Defence, *Submission 34*, p. 14.

54 Department of Defence, *Submission 34*, p. 14.

55 Department of Defence, *Submission 34*, p. 14.

56 Department of Defence, *Submission 34*, p. 19.

### *Post-deployment*

4.46 During a member's first week back in Australia the BattleSMART brief is reinforced and the member is provided with local mental health and welfare support contacts. A Post-Operational Psychological Screen (POPS) is provided within three to six months of the member's return from deployment. This aims to 'identify ADF personnel who are having reintegration difficulties with family, civilian community and routine military duties following their deployment, and facilitates the member in accessing the appropriate support'.<sup>57</sup>

### **Mental health services available to veterans**

4.47 A number of submissions highlighted the quality and range of mental health support services available to veterans.<sup>58</sup> Walking Wounded commented that, 'DVA provides a very broad range of mental health support and it would be churlish to disparage these genuine and often difficult services'.<sup>59</sup> Phoenix Australia commended DVA for its provision of a 'broad range of options for veterans with mental health problems', describing it as 'probably as good as anywhere else in the world':

DVA has been among the world leaders for over twenty years in the provision of high quality PTSD treatment for veterans. These programs, all of which comply with key content and performance criteria, all of which participate in a standardised outcome evaluation process, and all of which have a commitment to continuous improvement, have demonstrated impressive outcomes in terms of symptom reduction and improved quality of life. DVA has also developed a valuable range of online and mobile mental health resources for veterans and practitioners and continues to seek to harness e-health options to enhance its service delivery systems.<sup>60</sup>

4.48 However, some submissions noted that many veterans may not be able to access these services.<sup>61</sup> The Australian Psychological Society (APS) noted that although its members reported that many DVA programs are of high quality and are specifically designed to find effective solutions to improve mental health and wellbeing of veterans, 'current service models do not effectively reach a large number of veterans'. The APS asserted that this is in part due to the 'limitations in the breadth and number of services available' and identified three specific groups of veterans who

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57 Department of Defence, *Submission 34*, p. 14.

58 For example: Walking Wounded, *Submission 18*, p. 4; Phoenix Australia, *Submission 30*, p. 6; Australian Psychological Society, *Submission 22*, pp 9–10; Soldier On, *Submission 29*, p. 8.

59 Walking Wounded, *Submission 18*, p. 4.

60 Phoenix Australia, *Submission 30*, p. 6.

61 For example: Mr Robert Shortridge, *Submission 16*, p. 5; Walking Wounded, *Submission 18*, p. 3; Australian Psychological Society, *Submission 22*, pp 9–10; Psychotherapy and Counselling Federation of Australia, *Submission 23*, pp 1, 6; Mr Jeremy Davey, *Submission 25*, p. 4; Soldier On, *Submission 29*, p. 8; Dr Kieran Tranter, *Submission 27*, p. 20; Phoenix Australia, *Submission 30*, p.6; Veterans' Health Advisory Council (South Australia), *Submission 55*, pp 7–8; Australian Association of Social Workers, *Submission 77*, p. 4.

are particularly disadvantaged by an absence of services: veterans in Tasmania, veterans in rural and remote areas, and veterans with physical disabilities.<sup>62</sup>

4.49 The Veterans' Health Advisory Council (South Australia) criticised the DVA's divestment of veterans' health assets and its move to a purchaser-provider model. The Council asserted that this has led to the loss of military-specific specialists:

The existence of DVA run hospitals meant that there was a group of medical and allied health specialists to both assist veterans in clinical matters and advocate for them in broader health delivery and community contexts. Specialist medical and allied health professionals with knowledge of the veteran community operated as a conduit of clinical information about the service needs of DVA veterans. With the transfer and closure of the DVA hospitals, Australia will be in a unique position of having a Department of Veterans Affairs that will have divested itself of health assets.<sup>63</sup>

4.50 DVA advised the committee that its focus for mental health is 'firmly on early intervention'. DVA told the committee that funding for veterans' mental health treatment is demand-driven, stating that 'where treatment is required it is funded' and noted that the government is investing in the improvement of mental health services for veterans:

The benefits of early intervention are clear, both for the veteran and their family. Recent Government budget initiatives further highlight the commitment to treating mental health conditions. Over recent years, significant funding has been invested in new initiatives aimed at improving the mental health of veterans, from improved access to treatment and counselling, through to improvements in the Department's management of clients with complex needs, including those with mental health conditions.<sup>64</sup>

4.51 DVA's expenditure on mental health has been steadily increasing from \$160.9 million in 2009-10 to \$178.6 million in 2012-13. The breakdown of the expenditure for mental health in 2012-13 is outlined in Table 4.1.

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62 Australian Psychological Society, *Submission 22*, pp 9–10;

63 Veterans' Health Advisory Council (South Australia), *Submission 55*, p. 1.

64 Department of Veterans' Affairs, *Submission 35*, p. 3.



**Table 4.1–DVA mental health expenditure 2012-13**

Category	\$m	Description
Mental health budget measures	3.6	Population measures including At Ease website; mobile phone applications; and provider engagement training and resources.
General Practitioners	24.0	Provide mental health assessment and access to treatment.
Allied Mental Health Workers	3.1	Provide assessment and consultations, including group and individual therapies from professionals such as psychologists or social workers.
VVCS	27.3	Counselling support and mental health treatment by psychologists and social workers. Includes case management services, group programmes and psycho-education programs.
Psychiatrists	18.8	Provide psychiatric assessments, diagnoses, medicine management and clinical reviews as well as ongoing treatment.
Pharmaceutical	26.5	Includes anti-depressants, psycho stimulants and dementia-related drugs.
Private Hospitals	36.6	Contracts with private hospitals for the purchase of emergency, acute care and outpatient mental health services for the veteran community.
Public Hospitals	37.3	Arrangements with all state and territory governments. Public and private hospitals expenditure also includes trauma recovery programmes for post traumatic stress disorder provided in hospitals around the country.
Phoenix Australia (formerly Australian Centre for Posttraumatic Mental Health)	1.4	Provides evidence based expert advice to inform and underpin DVA's policies and programs.
<b>Total</b>	<b>178.6</b>	

4.52 DVA assured the committee that it has a 'strong focus' on purchasing evidence-based care and that it 'puts a strong focus on research and quality to underpin its purchasing'. DVA noted that it partners with clinical experts such as Phoenix Australia to develop resources regarding veteran-specific mental health issues for providers, including:

- Mental Health Advice Book: which aims to update the knowledge base of practitioners who regularly treat veterans, as well as inform those who may be less familiar with veterans' mental health issues;
- Veteran Mental Health Consultation Companion: an app that offers practitioners evidence-based consultation checklists and interactive assessment measures with automatic score calculations and Australian military interpretations. It is available on both iOS and android;
- Online training programs in veteran mental health: providing training modules such as Understanding the Military Experience, Case Formulation, and PTSD Psychological Interventions; and
- Evidence Compass: a website whereby research literature is organised, reviewed, synthesised, and disseminated on questions of high importance to the treatment of veterans.<sup>65</sup>

4.53 DVA advised the committee that veterans also have access to the online resources available to Defence members (discussed above) including DVA's mental health website 'At Ease' which 'focuses on promoting mental health and wellbeing, or resilience'. The website provides a range of mobile apps as well as videos of veterans talking about mental health recovery. DVA noted that it also implements health and wellbeing programs, in partnership with the veteran ex-service community.<sup>66</sup>

### ***Schedule of fees for psychologists***

4.54 The committee received evidence raising concerns regarding DVA funding schedules for mental health services.<sup>67</sup> One submitter noted it was difficult for veterans to find a psychologist who would accept the DVA White Card:

We do have a concern that the DVA White Card schedule of fees for psychological treatment are well below the current fees suggested by the Australian Psychological Society; and the rate that many psychologists usually charge. This can cause delays when veterans seek the help of a psychologist or psychiatrist, as you need to locate a practitioner who accepts the White Card. In our experience it can also create additional demand on services in particular locations where there are fewer practitioners that accept the White Card or where there are large numbers of veterans requiring services.<sup>68</sup>

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65 Department of Veterans' Affairs, *Submission 35*, pp 40–41.

66 Department of Veterans' Affairs, *Submission 35*, p. 4.

67 Name withheld, *Submission 44*, p. 4; Dr Kevin Kraushaar, *Submission 64*, p. 2.

68 Name withheld, *Submission 44*, p. 4.

4.55 This concern was also raised by Dr Kevin Kraushaar, a psychologist who has treated and is currently treating a number of veterans for mental ill-health. Dr Kraushaar advised the committee that many psychologists are unwilling or unable to treat veterans due to inadequate funding for psychological services.<sup>69</sup> Dr Kraushaar drew the committee's attention to the differences in the DVA psychologists' schedule of fees and the Australian Psychological Society's schedule of recommended fees, outlined in Table 4.2.

**Table 4.2–Comparison of DVA psychologists schedule of fees and Australian Psychological Society's schedule of recommended fees**

<b>DVA Item Number</b>	<b>Item description</b>	<b>DVA Fee*</b>	<b>APS recommended fee**</b>
US11	20 – 50 minutes consultation (in rooms)	\$71.85	\$131-\$238
US12	20 – 50 minutes consultation (out of rooms)	\$97.80	\$131-\$238 in addition to travel time (between \$48 - \$275)
US14	50+ minutes consultation (in rooms)	\$101.45	\$248-\$447 (up to 120 minutes)
US15	50+ minutes consultation (out of rooms)	\$127.45	\$248-\$447 (up to 120 minutes) in addition to travel time (between \$48 - \$275)

\* GST Free

\*\* Not including GST

Department of Veterans' Affairs, *Psychologists Schedule of Fees*, effective 1 November 2013, <http://www.dva.gov.au/sites/default/files/files/providers/psychol.pdf>, accessed 5 February 2016; Australian Psychological Society, *APS National Schedule of Recommended Fees (not including G.S.T) and item numbers for psychological services*, effective 1 July 2015 to 30 June 2016, <https://www.psychology.org.au/Assets/Files/2015-16-APS-IS-SRF.pdf>, accessed 5 February 2016.

4.56 Dr Kraushaar noted that 'multiple daily sessions are not claimable' and explained that such a policy could ultimately result in the suicide of veterans in crisis:

The issue of multiple sessions per day in crisis situations needs to be addressed especially for PTSD veterans in crisis...if [I] had not answered

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69 Dr Kevin Kraushaar, *Submission 64*, p. 2.

all four suicide intervention calls and other multiple day-sessions [my veteran client] with severe PTSD wouldn't be alive today.<sup>70</sup>

### **Veterans and Veterans Families Counselling Service (VVCS)**

4.57 A significant number of submissions expressed support for the work of the Veterans and Veterans Families Counselling Service (VVCS).<sup>71</sup> Walking Wounded commented that the VVCS 'has continued to grow and adapt to changing circumstances and demographics and, while it has its challenges, we are confident that its direction is sound'.<sup>72</sup> One submitter, who is the partner of a veteran, expressed their gratitude for the VVCS:

I can speak very highly of the service provided by the Veterans and Veterans Families Counselling Service (VVCS) to me as a partner. I was assessed over the phone by an experienced and empathetic support person and was given access to a psychologist promptly. My psychologist is excellent, and the work I have done with her has been invaluable. I am very grateful for the service that VVCS offer.<sup>73</sup>

4.58 DVA advised that the VVCS provides free and confidential counselling and support for veterans, peacekeepers and families. In 2013-14, VVCS:

- delivered 89,513 counselling sessions to 14,136 clients;
- delivered group programs to 2,074 clients;
- provided 5,526 intake services that did not lead to counselling; and
- received 7,050 calls to its after-hours crisis counselling service, Veterans Line.<sup>74</sup>

4.59 The VVCS provides 'free and confidential, nation-wide counselling and support for war and service-related mental health and wellbeing conditions'. DVA described it as 'a family inclusive organisation' where 'support is also available for relationship and family matters that can arise due to the unique nature of military

70 Dr Kevin Kraushaar, *Submission 64*, p. 2.

71 For example: Vietnam Veterans Federation of Australia, *Supplementary Submission 2.2*, p. 2; Mr Mark Keynes, *Submission 10*, p. 2; Mr Robert Shortridge, *Submission 16*, p. 4; Walking Wounded, *Submission 18*, p. 4; Mr Robert Sherman, *Submission 21*, p. 4; Australian Psychological Society, *Submission 22*, p. 11; Psychotherapy & Counselling Federation of Australia, *Submission 23*, p. 4; Dr Annabel McGuire, *Submission 24*, p. 3; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 23; Dr Kieran Tranter, *Submission 27*, pp 22–26; War Widows' Guild of Australia, *Submission 28*, p. 3; Soldier On, *Submission 29*, pp 4–8; Phoenix Australia, *Submission 30*, p. 6; Legacy Australia, *Submission 39*, p. 2; Partners of Veterans Association of Australia, *Submission 42*, p. 1; Name withheld, *Submission 44*, p. 4; Veterans' Health Advisory Council (South Australia), *Submission 55*, p. 8.

72 Walking Wounded, *Submission 18*, p. 4.

73 Name withheld, *Submission 44*, p. 4.

74 Department of Veterans' Affairs, *Submission 35*, p. 7.

service'.<sup>75</sup> A breakdown of the demand for VVCS services since 2009-10 is listed in Table 4.3 below.

**Table 4.3– VVCS Services**

Description	Number per financial year				
	2009-10	2010-11	2011-12	2012-13	2013-14
Counselling sessions delivered	53,164	57,405	63,651	73,063	89,513
Intake not leading to counselling	2,348	2,972	3,354	4,232	5,526
Group programs	3,181	3,395	2,897	2,488	2,074
Veterans Line	4,610	5,332	5,497	5,306	7,050

Department of Veterans' Affairs, *Submission 35*, p. 44.

4.60 DVA advised the committee that the VVCS has a counselling centre in every capital city as well as in a counselling centre in a range of major regional centres with large ADF and veteran populations, such as Townsville. From 2010, VVCS has also applied a 'satellite centre' model which enables clients to access VVCS staff clinicians through medical supercentres or services offices located near ADF bases. VVCS also maintains a national network of contracted outreach counsellors comprised of both psychologists and mental health-accredited social workers to provide services to clients for whom travel to a VVCS centre is impractical.<sup>76</sup>

4.61 DVA informed the committee that VVCS clients are 'connected to support 24 hours a day' through the national 1800 number (1800 011 046) that connects clients to the nearest VVCS counselling centre during business hours and functions as the VVCS crisis telephone counselling line, Veterans Line, after hours.<sup>77</sup>

### *Eligibility*

4.62 A number of submissions raised concerns regarding the eligibility requirements for VVCS.<sup>78</sup> Solider On noted that unlike veterans, ADF members cannot access VVCS directly, instead requiring a referral from a Medical Officer or Psychologist. Furthermore, the VVCS is required to report to the ADF on the

<sup>75</sup> Department of Veterans' Affairs, *Submission 35*, p. 42.

<sup>76</sup> Department of Veterans' Affairs, *Submission 35*, p. 44.

<sup>77</sup> Department of Veterans' Affairs, *Submission 35*, p. 44.

<sup>78</sup> For example: Vietnam Veterans Federation of Australia, *Supplementary Submission 2.2*, p. 2; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 23; Soldier On, *Submission 29*, pp 4–8; Partners of Veterans Association of Australia, *Submission 42*, p. 1.

member's mental health. Soldier On asserted that this limits the usability of the service for ADF members, who may wish to seek help but do not want the ADF to know that they are receiving counselling:

Recently, the MoU has been expanded to allow for Medical Officers (MO) or Psychologists in the ADF to refer members presenting to their Health Centres to the Veteran and Veterans Families Counselling Service (VVCS). This is an excellent step, however access to these services is predicated on the member first presenting to an MO or psychologist and receiving a referral. This in itself can represent a barrier to members seeking help, due to the realistic fear that disclosing signs of PTSD or other mental health conditions will jeopardise or end their military career. This potentially means many do not seek treatment whilst they are serving, even as symptoms of psychological wounds develop or worsen. This is especially problematic as early intervention and treatment of mental health conditions is related to improved outcomes.<sup>79</sup>

4.63 The following members of the veteran and defence community presenting with mental health and wellbeing concerns can seek help from the VVCS:

- veterans, whether current or former serving with the ADF;
- other current and former ADF members who have:
  - served in domestic or international disaster relief operations;
  - served in border protection operations;
  - served in the Royal Australian Navy as a submariner;
  - been medically discharged; or
  - been involved in a training accident that resulted in serious injury to any person;
- participants in the Veterans' Vocational Rehabilitation Scheme;
- certain United Nations and Australian police approved peacekeepers;
- the partners and dependent children (up to age 26) of those members listed above;
- the ex-partners of Vietnam veterans within five years of separation;
- sons and daughters (of any age) of Vietnam veterans;
- war widow(er)s
- those with a DVA Health Card – for All Conditions (Gold);
- those with a DVA Health Card – for Specific Conditions (White) for specified mental health conditions;
- the partners, dependent children and parents of members killed in service-related incidents;

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79 Soldier On, *Submission 29*, p. 4.

- participants in the Study of Health Outcomes in Aircraft Maintenance Personnel scheme; and
- current serving members who are referred to VVCS by the ADF under an Agreement for Services.<sup>80</sup>

4.64 DVA advised the committee that the eligibility for VVCS services extends to a broad range of people across the veteran and ex-service community and assured the committee that, even if not eligible, members of the veteran and ex-service community who are in need or distress are not turned away:

...VVCS does not turn away members of the veteran and ex-service community who are in need or distress. VVCS is able to provide limited counselling as part of its duty of care and can refer people who need ongoing support and are not eligible for its services to more appropriate support options.<sup>81</sup>

4.65 DVA also noted that a person seeking assistance from the VVCS may have clinical needs outside VVCS' core business or clinical skill bases. Such people may need to be referred to specialist mental health services such as trauma recovery programs for PTSD, hospital psychiatric services, drug and alcohol services, or child and adolescence mental health services.<sup>82</sup>

#### *Recognition of registered counsellors*

4.66 The Australian Counselling Association advised the committee that the VVCS only use psychologists and registered mental health social workers and that 'Medicare only allows for rebates to psychologists, psychiatrists and some social workers'. The Australian Counselling Association called for registered counsellors to be recognised and utilised by the VCAA, asserting that this would 'significantly open access to services for veterans and more importantly their families'.<sup>83</sup>

### **Mental health services available to partners, carers, and families**

4.67 Chapter 2 discussed the impact an ADF member or veteran's mental ill-health can have on their family and the importance of assisting families as they support a member or veteran struggling with mental ill-health. Slater & Gordon Lawyers highlighted the strain placed on families, and partners in particular, describing them as 'at the forefront...trying to be the treater and the provider and keeping the family together with someone who has got major psychological problems'.<sup>84</sup>

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80 Veterans and Veterans Families Counselling Service, <http://www.vvcs.gov.au/Clients/eligibility-at-a-glance.htm>, accessed 20 August 2015.

81 Department of Veterans' Affairs, *Submission 35*, p. 43.

82 Department of Veterans' Affairs, *Submission 35*, p. 43.

83 Australian Counselling Service, *Submission 17*, p. 3.

84 Mr Brian Briggs, Practice Group Leader, Military Compensation, Slater & Gordon Lawyers, *Committee Hansard*, 1 September 2015, p. 20.

4.68 A number of submissions commented on the support available for partners, carers, and families of ADF members and veterans struggling with mental ill-health.<sup>85</sup> The RSL asserted that 'enhanced outcomes for veterans with mental and/or physical injuries were linked to the support received by the carer' and that at present 'the support is insufficient'. The RSL identified key elements of support for families, including:

- access to information about the ADF members' or veterans' condition, how best to manage their condition at home, and the services available to support them and the member or veteran;
- relationship support;
- carer's ability to provide care, especially long-term;
- impact on children's mental health and recognition of children's needs;
- health support for carers; and
- practical help for carers.<sup>86</sup>

4.69 Some submissions raised the importance of practical support for families struggling with mental ill-health, especially with regards to childcare.<sup>87</sup> The Partners of Veterans Association of Australia noted that support services such as childcare is essential to ensure that partners of ADF members and veterans are able to properly access mental health services:

Effective counselling needs to be in a calm format where the communication between client and counsellor can be relaxed, therapeutic and where trust and confidence can be built. Most times that cannot occur if a child is present, for obvious reasons. If a partner is looking after and juggling home life with a person with a mental health problem and has small children, counselling will not be effective if they have not got babysitters or other child care.<sup>88</sup>

4.70 The RSL also noted that carers and families often expressed concerns regarding the financial impact of service-related injury or illness; the 'often hastened

85 For example: Mr Mark Keynes, *Submission 10*, p. 2; Walking Wounded, *Submission 18*, p. 4; Returned & Services League of Australia, *Submission 19*, pp 12–13; Australian Families of the Military Research and Support Foundation, *Submission 26*, pp 20–24; Dr Kieran Tranter, *Submission 27*, p. 26; Soldier On, *Submission 29*, p. 3; Legacy Australia, *Submission 39*, pp 1–4; Alliance of Defence Service Organisations, *Submission 40*, pp. 2–4; Name withheld, *Submission 43*, pp 1–3; Name withheld, *Submission 44*, p. 4; Miss Alanna Power, *Submission 48*, p. 3; Royal Australian Armoured Corps Corporation, *Submission 59*, pp 2–4; Dr Kevin Kraushaar, *Submission 64*, pp 11–12; Australian Association of Social Workers, *Submission 77*, pp 4–5.

86 Returned & Services League of Australia, *Submission 19*, pp 12–13.

87 Vietnam Veterans' Federation of Australia, *Supplementary Submission 2.2*, p. 2.; Partners of Veterans Association of Australia, *Submission 42*, p. 5; Returned & Services League of Australia, *Submission 19*, pp 12–13.

88 Partners of Veterans Association of Australia, *Submission 42*, p. 5.



departure from Defence' and subsequent sudden loss of support networks and housing; legal issues associated with relationships, powers of attorney, guardianship, superannuation and finances; 'inadequate separation planning from Defence'; and transition support for medically discharged veterans and their families.<sup>89</sup>

### ***ADF members' families***

4.71 Defence advised the committee that it is committed to developing a family-sensitive approach to the delivery of mental health, psychology, and rehabilitation services delivered to ADF members. Defence noted that the Defence Community Organisation (DCO) provides 'a comprehensive range of support options for Defence families and members and can be accessed directly at regional DCO offices or via the Defence Family Helpline', including the provision of brief interventions:

Defence Community Organisation regionally based social workers and Defence Family Helpline staff are able to provide brief interventions to families which can include assisting the family member or partner with their own support system, discussing strategies to enhance help seeking and supporting treatment, options to access treatment, exploring strategies to deal with volatility and anger and also withdrawal and anticipating and managing triggers.<sup>90</sup>

4.72 The DCO also provides a range of family support programs to help inform families, develop their psychological resilience, and improve family and social connectedness. The DCO publishes the magazine 'Defence Family Matters' three times a year for Defence families as well as providing resources through its website regarding suicide prevention; encouraging a loved one to seek help; supporting families of wounded, injured, or ill ADF members; ADF members experiencing trauma; and preparing your family for the return of deployed member. The DCO also provide support calls to the families of deployed members 'which provide the opportunity for family members to raise any concerns'.<sup>91</sup>

4.73 Other support available to Defence families include:

- ADF Family Health program, which provides financial support to Defence families when accessing community health care (100 per cent coverage for General practice treatments and a capped amount for specialist care);
- access to the range of mental health promotion resources and service guides for available rehabilitation programs at the ADF Health and Wellbeing website and DVA 'At Ease' website;
- access to the Veterans and Veterans Families Counselling Service (VVCS), subject to eligibility; and

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89 Returned & Services League of Australia, *Submission 19*, pp 12–13.

90 Department of Defence, *Submission 34*, p. 15.

91 Department of Defence, *Submission 34*, pp 15–16.

- access to the ADF All-Hours Support Line and Defence Family Helpline.<sup>92</sup>

### ***Veterans' families***

4.74 DVA told the committee it recognised that 'supportive families of veterans can help protect veterans' mental health and encourage them to seek treatment for mental health concerns when it is needed', but that 'at the same time, family members and carers may need their own mental health support'.<sup>93</sup> DVA advised that families have access to the same online resources as veterans and that counselling and support is provided to eligible family members through the VVCS.<sup>94</sup>

### **Committee view**

4.75 Accurate diagnoses and effective evidence-based treatments are the best way to ensure that ADF members and veterans are able to manage mental ill-health and receive the best possible treatments. To this end, the committee strongly supports research efforts to better understand the prevalence, contributing factors, and treatments of mental ill-health in ADF members, veterans and their families, such as the Transition and Wellbeing Research Programme, led by the Centre for Traumatic Stress Studies (CTSS) at the University of Adelaide.

4.76 The committee acknowledges that the military population has its own unique mental health requirements and is concerned by evidence suggesting that evidence-based care guidelines developed for the civilian population may not meet the specific needs of ADF members and veterans.

### ***Neurological problems***

4.77 It is essential that ADF members and veterans who have incurred neurological damage are correctly diagnosed and given appropriate treatment to ensure that they can achieve the best possible outcomes. The committee is concerned by evidence that insufficient consideration is being given to neurology as a causative factor for mental ill-health in ADF members and veterans.

4.78 The committee is also concerned by the evidence it received regarding the neuropsychiatric effects of mefloquine. The committee acknowledges that mefloquine is used by Defence as a third line agent and that it is administered to a small percentage of the deployed population. However, it is essential that those ADF members and veterans who have been administered mefloquine are made aware of the possible short-term and long-term side effects and are given access to appropriate neurological assessment, particularly if they have exhibited symptoms of mental ill-health. The committee notes that the Inspector General of the Australian Defence Force is currently conducting an investigation into matters regarding the use of mefloquine.

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92 Department of Defence, *Submission 34*, pp 15–16.

93 Department of Veterans' Affairs, *Submission 35*, p. 19.

94 Department of Veterans' Affairs, *Submission 35*, p. 7.

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## **Recommendation 5**

**4.79** The committee recommends that Defence and DVA contact ADF members and veterans who have been administered mefloquine hydrochloride (mefloquine) during their service to advise them of the possible short-term and long-term side effects and that all ADF members and veterans who have been administered mefloquine during their service be given access to neurological assessment.

## **Recommendation 6**

**4.80** The committee recommends that the report for the Inspector General of the Australian Defence Force's inquiry to determine whether any failures in military justice have occurred regarding the Australia Defence Force's use of mefloquine be published immediately following the completion of the inquiry.

### ***Moral injury***

**4.81** The committee notes the evidence that it received regarding the impact of moral injury on ADF members' and veterans' mental health. The committee acknowledges that Defence is working to better understand and address concerns regarding moral injury, with the first element of this being a scoping study with Professor Frame. The committee looks forward to the publication of the findings of the scoping study.

### ***Adequacy of mental health services available to ADF members***

**4.82** The committee is satisfied that the ADF members' access to mental health services is adequate, provided the member is willing to seek treatment. The committee commends Defence for its proactive approach to mental health promotion, prevention and early treatment services for deployed members. The committee also commends Defence for the range of support services it provides to Defence families, particularly those services provided by the Defence Community Organisation.

**4.83** The committee is pleased with the range of mental health and psychology education programs as well as the resilience and crisis services available, many of which can be accessed by ADF members who might be reluctant to seek assistance (through the internet, through mobile apps, and via helplines). The committee acknowledges that stigma regarding mental ill-health continues to be a significant barrier to accessing mental health services; this is discussed in greater detail in Chapter 5 of this report.

**4.84** The committee is content that the Critical Incident Mental Health Support response (following members' exposure to potentially traumatic events) together with the Special Psychological Screen (for deployed members in high risk operational roles) align with the principles of early identification and treatment of mental health while on deployment.

**4.85** The committee notes that improvements can be made to the coordination of the delivery of care, particularly with regards to ensuring that medical officers and mental health professionals have ready access to records of potentially traumatic events for deployed members after deployment. Furthermore, communication and

coordination between mental health professionals and commanders, especially with regards to the ongoing care of members in a unit setting should be improved.

### **Recommendation 7**

**4.86 The committee recommends that the Department of Defence ensure that medical officers and mental health professionals have ready access to records of potentially traumatic events for members following their deployment.**

#### ***Adequacy of mental health services for veterans***

4.87 The committee commends DVA for its focus on early intervention and is satisfied that the range of mental health services available to veterans is adequate, provided their claim has been accepted by DVA. However, the committee is concerned that the services offered to families, primarily access to the VVCS, seem to be inconsistent.

4.88 The committee is concerned by the evidence that psychologists are unwilling or unable to treat veterans due to DVA providing inadequate funding for psychological services. The committee notes that there is a significant gap between the DVA schedule of fees and the Australian Psychological Society's schedule of recommended fees. The committee is concerned that inadequate funding of psychological services will limit the already scarce mental health services available to veterans (especially those living in regional or remote areas).

### **Recommendation 8**

**4.89 The committee recommends that the DVA Psychologists Schedule of Fees be revised to better reflect the Australian Psychological Societies' National Schedule of Recommended Fees and that any restrictions regarding the number of hours or frequency of psychologist sessions are based on achieving the best outcome and guaranteeing the safety of the veteran.**

#### ***Veterans and Veterans Families Counselling Service***

4.90 The committee commends the work of the VVCS—the service was widely praised by submitters and witnesses. The VVCS provides an invaluable 'first-stop' resource for ADF members, veterans and their families to seek assistance and advice regarding mental ill-health and the support and services available to assist them. The committee believes that access to the VVCS appears to be unnecessarily restricted by eligibility requirements. Eligibility should be consolidated and inconsistencies based on which conflict a veteran served in and other service requirements should be removed. Access should be broadened to include any current or former member of the ADF and their immediate family (partners, children, and carers).

4.91 The committee accepts the argument that the requirement that ADF members must be referred to the VVCS and the VVCS' responsibility to report to the ADF regarding members' mental health is likely to deter ADF members from accessing this valuable service. While the committee acknowledges the importance of the ADF being made aware of the mental health of its members, this should not outweigh the importance of ensuring that members are able to receive the care that they require. To this end, ADF members should be eligible to access VVCS without referral and the

VVCS reporting obligations should be limited to situations where the VVCS believes that a member's mental ill-health will compromise their safety or the safety of others.

**Recommendation 9**

**4.92 The committee recommends that eligibility requirements for the Veterans and Veterans Families Counselling Service (VVCS) be consolidated and broadened to include all current and former members of the Australian Defence Force (ADF) and their immediate families (partners, children, and carers).**

**Recommendation 10**

**4.93 The committee recommends that currently serving ADF members be eligible to access the Veterans and Veterans Families Counselling Service (VVCS) without referral and that the VVCS reporting obligations to the ADF be limited to situations where the VVCS believes that a members' mental ill-health will compromise their safety or the safety of others.**

