

The Senate

Foreign Affairs, Defence and Trade
References Committee

Mental health of Australian Defence Force
members and veterans

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Foreign Affairs, Defence and Trade Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Phone: + 61 2 6277 3535

Fax: + 61 2 6277 5818

Email: fadt.sen@aph.gov.au

Internet: http://www.aph.gov.au/senate_fadt

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Committee Membership

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Senator Chris Back, Deputy Chair	LP, WA
Senator Sam Dastyari	ALP, NSW
Senator David Fawcett	LP, SA
Senator Scott Ludlam	AG, WA
Senator Anne McEwen	ALP, SA

Substitute member

Senator Peter Whish-Wilson, AG, TAS substituted for Senator Scott Ludlam

Secretariat

Mr David Sullivan, Committee Secretary
Mr Owen Griffiths, Principal Research Officer
Ms Casey Mazzarella, Senior Research Officer
Ms Kimberley Balaga, Research Officer
Ms Shannon Ross, Administrative Officer

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Abbreviations

ABS	Australian Bureau of Statistics
ADF	Australian Defence Force
ADSO	Alliance of Defence Service Organisations
AFOM	Australian Families of the Military Research and Support Foundation
APS	Australian Public Service
APS	Australian Psychological Society
ASDS	Acute Stress Disorder Scale
AUDIT	Alcohol Use Disorders Identification Test
CDF	Chief of the Defence Force
CIMHS	Critical Incident Mental Health Support
CTSS	Centre for Traumatic Stress Studies
DCO	Defence Community Organisation
Defence	Department of Defence
DeHS	Defence eHealth System
Dunt Review	2009 Review of Mental Health Care in the ADF and Transition through Discharge
DVA	Department of Veterans' Affairs
ECT	electroconvulsive therapy
ESOs	Ex-Service Organisations
FSPOPS	Family Sensitive Post Operational Psychology Screens
Gold Card	DVA Health Card – for All Conditions
GP	General Practitioner
HSE	Healthy Soldier Effect
IGADF	Inspector General of the Australia Defence Force
JeHDI	Joint eHealth Data and Information

JHC	Joint Health Command
K10	Kessler Psychological Distress Scale
MEAO	Middle East Areas of Operations
MEAO study	2012 Middle East Area of Operations (MEAO) Health Study: Census Study Report
MEDICAS	Medical Casualty
MHP	Mental Health Professional
MHPW study	2010 ADF Mental Health Prevalence and Wellbeing Study
MHS	Mental Health Strategy
MHSCF Report	Australian Defence Force Mental Health Screening Continuum Framework Report
MHWAP	Mental Health and Wellbeing Action Plan
MHWS	Mental Health and Wellbeing Strategy
MO	Medical Officer
MoU	Memorandum of Understanding
MRCA	<i>Military Rehabilitation and Compensation Act 2004</i>
MSI-R	Major Stressors Inventory – Revised
MTF-2	Mentoring Taskforce-2
MTF-3	Mentoring Taskforce-3
NCO	Non Commissioned Officer
NOTICAS	Notification of a Casualty
OBAS	On Base Advisory Services
OHSP	Operational Health Support Plan
PCEHR	National Personal Controlled Electronic Health Record
PCL	Post-traumatic Checklist
PCS	Primary Care System
PCS	Post-Concussion Syndrome

PFA	psychological first aid
POPS	post-operational psychological screening
Privacy Act	<i>Privacy Act 1988</i>
PTSD	Post-traumatic stress disorder
RARA	Royal Australian Regiment Association
RSL	Returned and Services League of Australia
RtAPS	Return to Australia Psychological Screening
SES	Senior Executive Service
SMART	Self-Management and Resilience Training
SNCO	Senior Non Commissioned Officer
SOLAS	Supported Options in Lifestyle & Access Services
SPS	Special Psychological Screen
SRCA	<i>Safety, Rehabilitation and Compensation Act 1988</i>
TBI	Traumatic Brain Injury
TGA	Therapeutic Goods Administration
TSES–R	Traumatic Stress Exposure Scale – Revised
VEA	<i>Veterans Entitlements Act 1986</i>
VRB	Veterans Review Board
VVCS	Veterans and Veterans Families Counselling Service
White Card	DVA Health Card – for Specific Conditions

Recommendations

Recommendation 1

3.90 The committee recommends that Defence conduct annual screening for mental ill-health for all ADF members.

Recommendation 2

3.96 The committee recommends that the Australian National Audit Office conduct an audit into the scope and accuracy of recordkeeping of relevant clinical information collected or recorded during deployment regarding mental ill-health or potentially traumatic incidents.

Recommendation 3

3.100 The committee recommends that all veterans be issued with a universal identification number and identification card that can be linked to their service and medical record.

Recommendation 4

3.103 The committee recommends that the Department of Health and the Department of Veterans' Affairs ensure that e-health records identify veterans and that GPs are encouraged to promote annual *ADF Post-discharge GP Health Assessment* for all veterans.

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.

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.

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.

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.

Recommendation 11

5.62 The committee recommends that Defence mental health awareness programs do more to emphasise the benefit of early identification and treatment of mental ill-health for an ADF members' long-term career and encourage ADF members to plan beyond their next deployment.

Recommendation 12

5.63 The committee recommends that the Department of Defence and the Department of Veterans' Affairs develop a program to engage current and former ADF members, who have successfully deployed after rehabilitation for mental ill-health, to be 'mental health champions' to assist in the destigmatisation of mental ill-health.

Recommendation 13

5.68 The committee recommends that the Department of Veterans' Affairs be adequately funded to achieve a full digitisation of its records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims.

Recommendation 14

6.46 The committee recommends that the Department of Defence work with ex-service organisations to develop a transition mentoring program, which will connect every veteran with a trained mentor from the ex-service community to assist and guide them through the transition process.

Recommendation 15

6.48 The committee recommends that the Department of Veterans' Affairs review its rehabilitation assessment policy to ensure that junior-ranked members are not disadvantaged and all veterans are able to access rehabilitation, education, and re-skilling based on their individual needs and abilities and regardless of rank.

Recommendation 16

6.52 The committee recommends that the Department of Veterans' Affairs identify veterans who are receiving in-patient mental health care as at risk of homelessness and provide an ongoing psychosocial case manager to actively manage an 'at risk' veteran's care program until their mental health and living situation is stable.

Recommendation 17

6.54 The committee recommends that the Department of Veterans' Affairs work together with the Department of Human Services and RSL Lifecare to develop a program to address veteran homelessness based on the Homes for Heroes 'housing first approach' and focus on ongoing psychosocial support.

Chapter 1

Introduction

1.1 On 25 March 2015 the Senate referred the following matter to the Foreign Affairs, Defence and Trade References Committee for inquiry and report by 19 February 2016. On 2 February 2016, the Senate agreed to extend the reporting date for the inquiry to 29 February 2016, and then on 29 February 2016 agreed to further extend the reporting date to 15 March 2016. The terms of reference for this inquiry concerned the mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment, with particular reference to:

- a. the extent and significance of mental ill-health and post-traumatic stress disorder (PTSD) among returned service personnel;
- b. identification and disclosure policies of the ADF in relation to mental ill-health and PTSD;
- c. recordkeeping for mental ill-health and PTSD, including hospitalisations and deaths;
- d. mental health evaluation and counselling services available to returned service personnel;
- e. the adequacy of mental health support services, including housing support services, provided by the Department of Veterans' Affairs (DVA);
- f. the support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD;
- g. the growing number of returned service personnel experiencing homelessness due to mental ill-health, PTSD and other issues related to their service;
- h. the effectiveness of the Memorandum of Understanding between the ADF and DVA for the Cooperative Delivery of Care;
- i. the effectiveness of training and education offerings to returned service personnel upon their discharge from the ADF; and
- j. any other related matters.

Conduct of inquiry

1.2 The committee advertised the inquiry on its website and in the Australian newspaper. The committee also wrote to individuals and organisations likely to have an interest in the inquiry and invited them to make written submissions.

1.3 The committee received 82 submissions and 11 supplementary submissions to the inquiry. These submissions are listed at Appendix 1 and are published on the committee's website.

1.4 The committee held four public hearings on 31 August 2015 in Canberra, 1 September 2015 in Brisbane, 21 September 2015 in Canberra, and 18 November 2015 in Narrabeen. The witnesses who appeared at these hearings are listed at

Appendix 3 and the programs and Hansard transcripts of the hearings are published on the committee's website.

Past parliamentary inquiries

1.5 In June 2013, the Joint Standing Committee on Foreign Affairs, Defence and Trade tabled its report into the *Care of ADF Personnel Wounded and Injured on Operations*. The report found that the mental health of ADF members (current and former) is not well documented nor understood by the Defence organisations and made three recommendations to improve this understanding:

Recommendation 8

The Committee recommends that the Department of Defence publish periodic detailed written assessments on:

- the implementation of the recommendations of both the 2009 Review of Mental Health Care in the ADF and Transition through discharge, and the 2010 ADF Mental Health Prevalence and Wellbeing Study;
- the Australian Defence Force mental health reform program; and
- what additional enhancements have been made to current programs, as indicated in the Defence White Paper.¹

Recommendation 9

The Committee recommends that the departments of Defence and Veterans' Affairs undertake a study into psychological support of partners and families of Australian Defence Force (ADF) members and ex-ADF members. The Committee further recommends that the study be conducted with the objective of developing recommendations to overcome partners' and families' mental health issues that may be highlighted by the study.

The Committee further recommends that the Government implement, as a priority, the recommendations of *The Health and Wellbeing of Female Vietnam and Contemporary Veterans* report.²

Recommendation 10

The Committee recommends that the effectiveness of psychological first aid be made a research priority by the Department of Defence, in consultation with the Department of Veterans' Affairs.³

1.6 The Returned and Services League of Australia (RSL) expressed disappointment with the government's progress implementing the recommendations of this inquiry and other past inquiries:

1 Joint Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations*, June 2013, p. 75.

2 Joint Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations*, June 2013, p. 76.

3 Joint Committee on Foreign Affairs, Defence and Trade, *Care of ADF Personnel Wounded and Injured on Operations*, June 2013, p. 76.

It is with considerable disappointment that the earlier, excellent [i]nquiries held over the previous decade have failed to produce the necessary follow-up they so rightly deserved. Too few of the recommendations were adequately pursued and we now find ourselves in much the same position once more...on close examination it can be seen that many of these excellent reforms have failed to come to pass or they have produced less benefit than they intended to implement.⁴

1.7 The government response to the report's recommendations was tabled in March 2015. Recommendations 8 and 10 were supported and recommendation 9 was supported in principle.

Structure of report

1.8 The report is structured as follows:

- Chapter 2 considers the extent and significance of mental ill-health in ADF members, veterans, and the families of ADF members and veterans;
- Chapter 3 considers the mental health strategies for ADF members and veterans; identification and disclosure policies in the ADF in relation to mental ill-health; and recordkeeping for mental ill-health for ADF members;
- Chapter 4 considers the diagnosis and treatment of mental ill-health and the adequacy of mental health support services provided to ADF members, veterans, and their families;
- Chapter 5 considers the barriers to accessing mental health services for ADF members and veterans, primarily their reluctance to seek help. It also focuses on the difficulties and challenges experienced by ADF members and veterans seeking assistance through DVA delivery models and claims processes, including ADF members and veterans who live in regional and remote areas; and
- Chapter 6 considers the effectiveness of training, education, and transition support services provided to ADF members at discharge; the Memorandum of Understanding (MoU) between the ADF and DVA and the effective transfer of responsibility of care; and veterans experiencing homelessness due to mental ill-health and other issues related to their service.

Definitions

1.9 The committee acknowledges that there is more than one definition for the term 'veteran' and that the term means different things to different people. The *Veterans' Entitlement Act 1988* defines a veteran as a person who is 'taken to have rendered eligible war service';⁵ and the term is not specifically defined by the *Military Rehabilitation and Compensation Act 2004*, rather it notes the kinds of service to

4 Returned and Services League of Australia, *Submission 19*, p. 19.

5 *Veterans' Entitlement Act 1988*, ss. 5C(1).

which the act applies, listing warlike service, non-warlike service, peacetime service and defence service.⁶

1.10 This report uses the term 'veteran' to describe all former members of the ADF, irrespective of whether they were deployed or undertook war or warlike service.

Acknowledgements

1.11 The committee thanks all those who contributed to the inquiry by making submissions, providing additional information or appearing at the hearings.

6 *Military Rehabilitation and Compensation Act 2004*, ss. 6(1).

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.

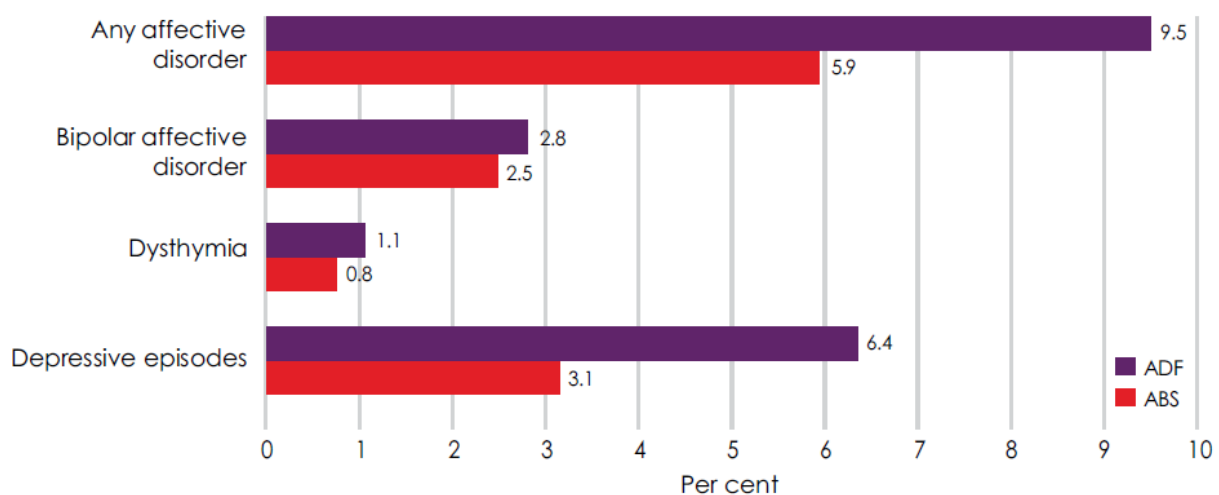
Table 2.1–Estimated prevalence of lifetime and 12-month disorders

	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

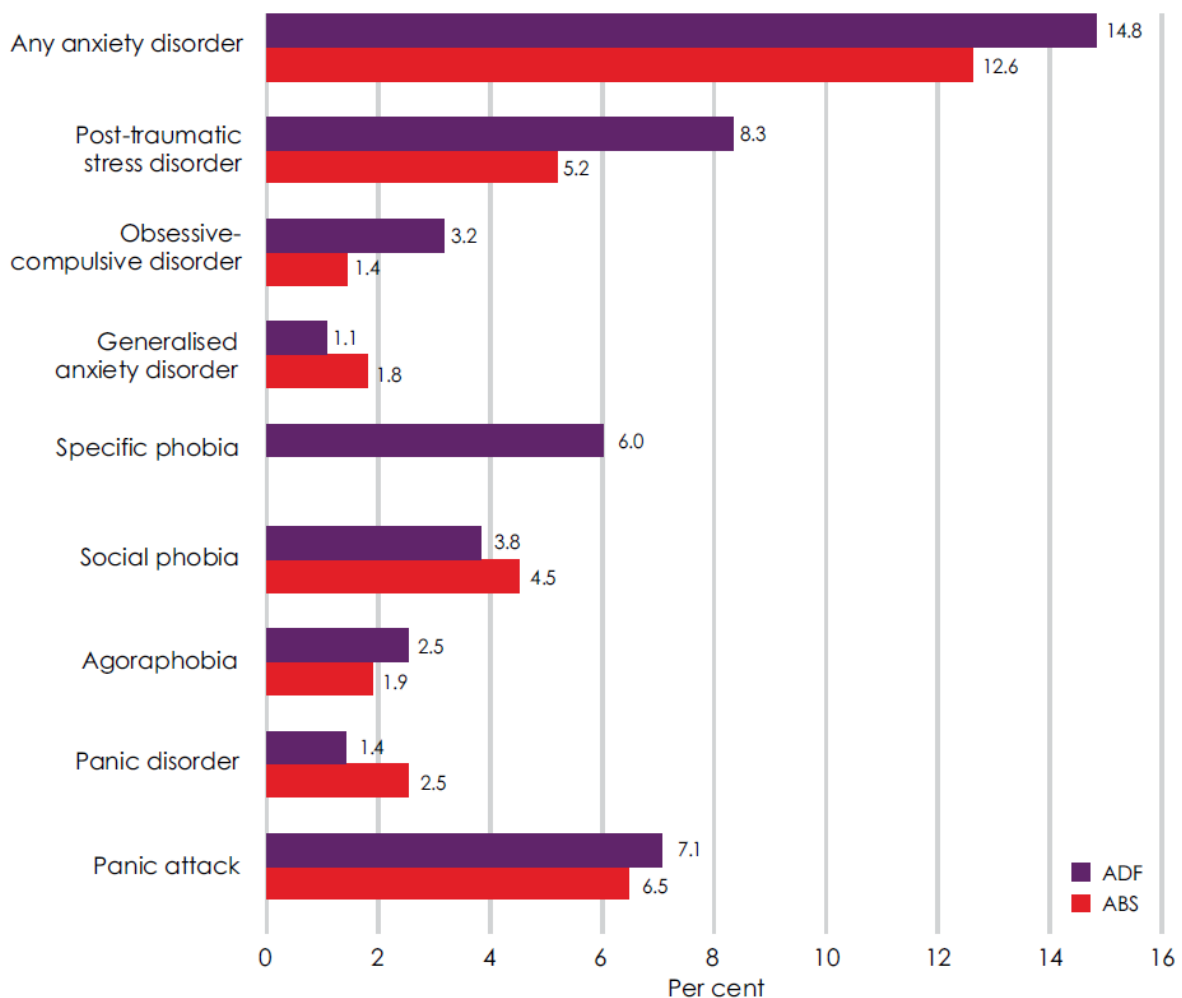
Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xix.

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



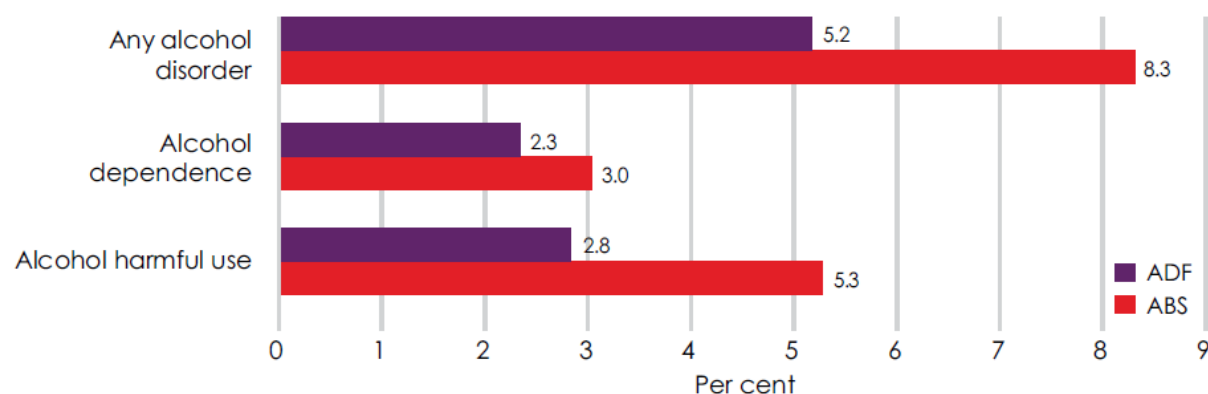
Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xix.

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

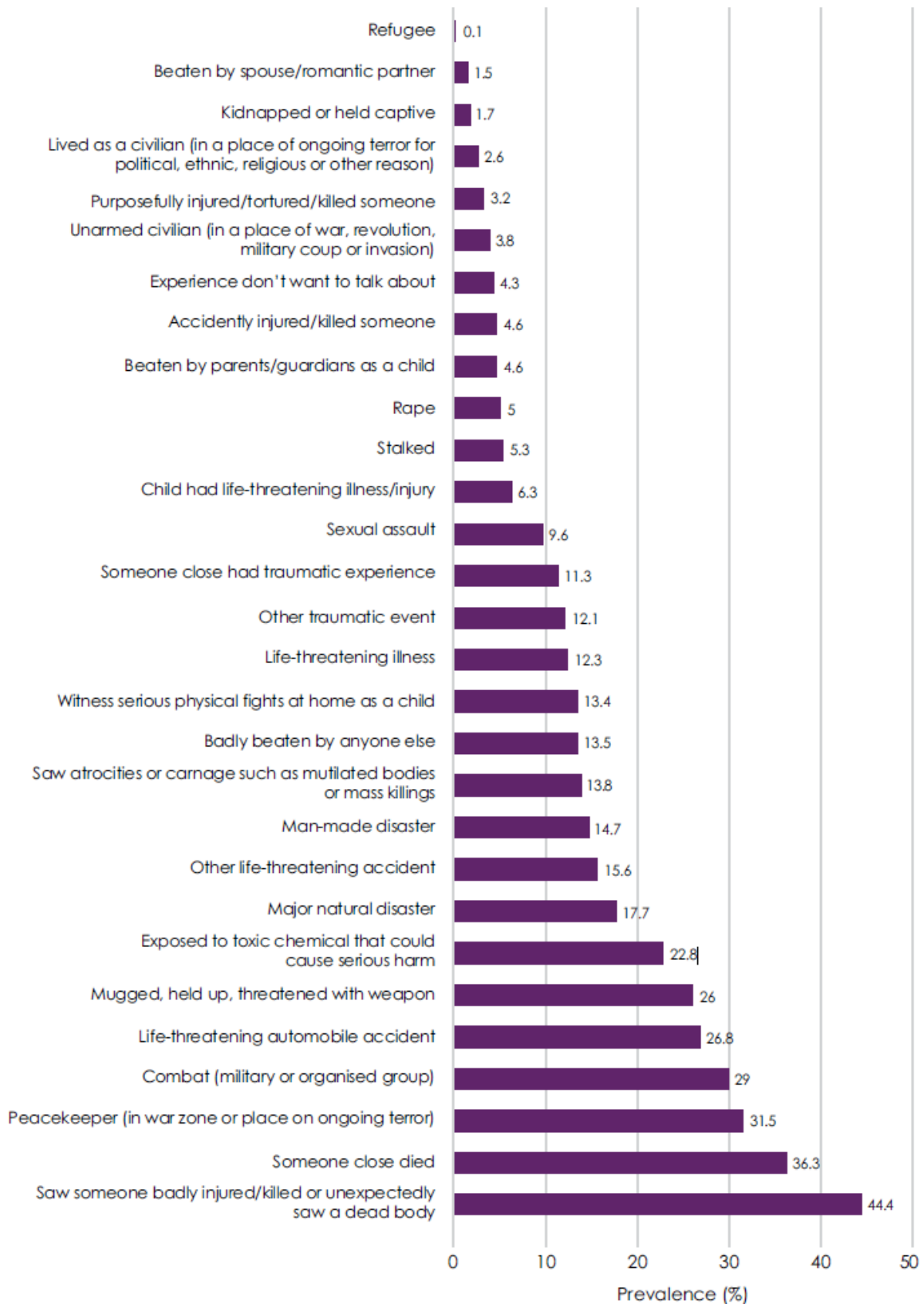
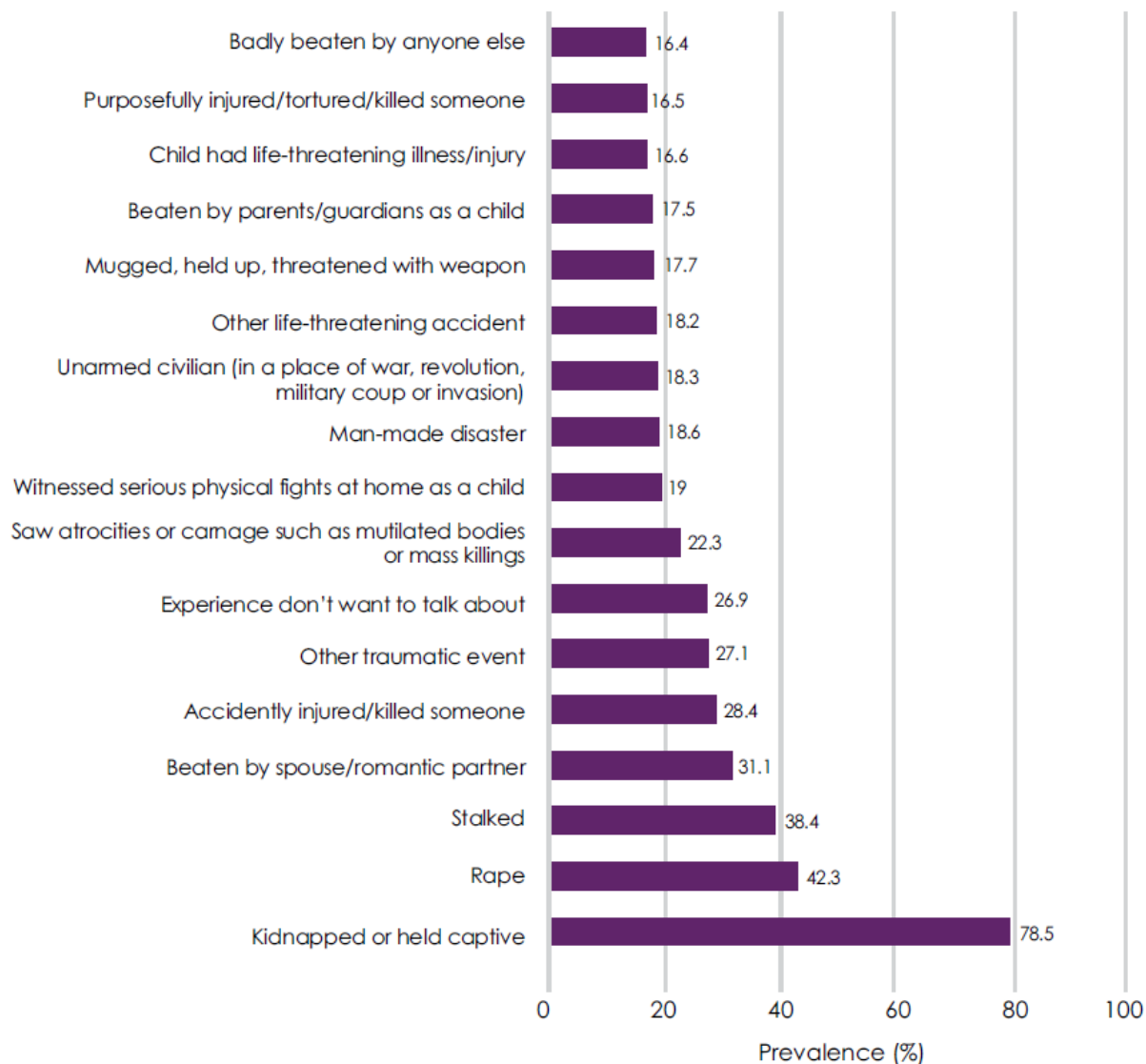


Figure 2.5—Estimated prevalence of post-traumatic stress disorder from specific event types



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

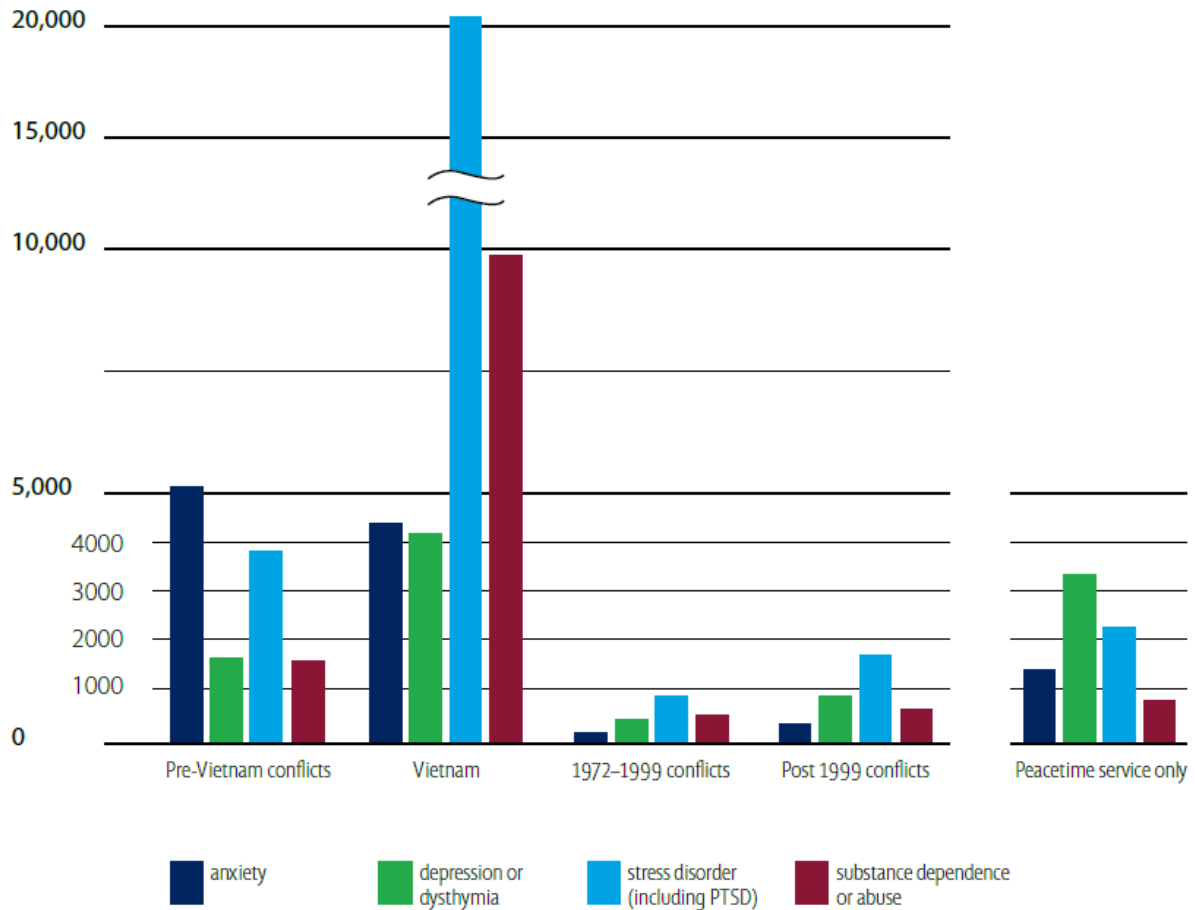
* Note: This table is a count of claims. Some individuals are counted multiple times.

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

41 Mr Ciaran Hemmings, *Committee Hansard*, 1 September 2015, p. 35.

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.

Chapter 3

Identification and disclosure of mental ill-health

Introduction

3.1 This chapter considers the mental health strategies for ADF members and veterans; identification and disclosure policies in the ADF in relation to mental ill-health; and recordkeeping for mental ill-health for ADF members.

ADF Mental Health Strategies

3.2 In 2002 the Department of Defence (Defence) developed its first Mental Health Strategy (MHS), seeking to promote mental health and wellbeing as well as raise awareness of suicide and the misuse of alcohol, tobacco, and other drugs. In 2009, the *Review of Mental Health Care in the ADF and Transition through Discharge* (commonly referred to as the Dunt Review) was published. The Dunt Review praised the ADF finding that its MHS compared favourably to mental health strategies from militaries in other countries:

The establishment of the MHS by the ADF in 2002 was far-sighted. The Strategy compares favourably with mental health strategies in other Australian workplaces. It also compares favourably with what exists in military forces in other countries. Some of these military forces have mental health policies and programs in place, particularly in relation to PTSD. Others have individual mental health programs in place however they do not have the suite of programs at a whole of forces level that exists in the ADF. The enthusiasm and commitment of ADF members in delivering these programs adds to the ongoing achievement of the MHS. This has meant that programs are well received by members.¹

3.3 The Dunt Review noted that, despite its achievements, the ADF's Mental Health Strategy needed further improvement 'for it to truly be a Strategy, rather than a small number of small programs as at present'.² The Dunt Review made 52 recommendations.³

ADF Mental Health Reform Program

3.4 Defence commenced the Mental Health Reform Program in 2010, based substantially on the findings and recommendations of the Dunt Review.⁴ Defence invited a number of external mental health experts, clinicians, policy advisors and

1 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, p. 16.

2 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, p. 16.

3 Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009, pp 21–27.

4 Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, p. 5.

researchers (including Professor Dunt) to form the Mental Health Advisory Group, together with representatives of Joint Health Command (JHC), single Services, Defence Community Organisation, Defence Families Association, Department of Veterans' Affairs (DVA) and the Veterans and Veterans Families Counselling Service (VVCS). The Group has met seven times.⁵

3.5 In 2011, Defence released its Mental Health and Wellbeing Strategy (MHWS) and in 2012 released the supporting Mental Health and Wellbeing Action Plan (MHWAP).⁶ The MHWAP lists six strategic objectives and the priority actions that need to be taken to achieve them (see Table 1.1). The MHWAP also outlines the goals and deliverables and describes 'what success will look like', for each of the objectives.⁷ The Chief of the Defence Force (CDF), Air Chief Marshal Mark Binskin AC, outlined Defence's achievements in the area of mental health since 2009:

...we have upskilled and increased our mental health workforce as well as strengthened our resilience training and prevention strategies, which now begin at recruitment. We have improved the screening programs used to identify problems and we have also undertaken world-class mental health research and surveillance. As a result, we know more now than at any point in our history about the impact military service can have on the mental, physical and social health of current and ex-serving personnel. We have a comprehensive body of data about the causes and prevalence of mental health issues in the Australian Defence Force population.⁸

3.6 Defence advised the committee that it has implemented all 52 of the recommendations from the Dunt Review, investing \$146 million in mental health services and support (as at 30 March 2015). Defence has improved policy and training for Defence health professionals; increased mental health research and surveillance; and strengthened resilience training and prevention strategies.⁹

3.7 The Returned and Services League of Australia (RSL) commented on the MHWAP, stating that its priority actions, whilst positive, are far from achieved:

These hoped for outcomes have at best been only partially obtained at this point in time and a great deal more work is yet to be undertaken in order to achieve them. Too many individuals are suffering in poorly managed circumstances at the present time without the necessary care and supervision that's required from a number of appointed agencies.¹⁰

5 Department of Defence, *Submission 34*, p. 3.

6 Department of Defence, *Capability through mental fitness: 2011 Australian Defence Force Mental Health and Wellbeing Strategy*, October 2011; and Department of Defence, *ADF Mental Health and Wellbeing Action Plan 2012-2015*, October 2012.

7 Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, pp 12–25.

8 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, *Committee Hansard*, 29 September 2015, p. 1.

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

10 Returned & Services League of Australia, *Submission 19*, p. 7.

3.8 Consultations for the development of the *ADF Mental Health and Wellbeing Strategy 2016-2020* commenced in March 2015. The consultations are being led by Joint Health Command and 'will involve engagement with a broad range of stakeholders, both internal and external to Defence'.¹¹

Table 3.1 – Strategic objectives and priority actions of the ADF Mental Health and Wellbeing Plan 2012-15

Strategic Objectives	Priority Actions
Promote and support mental fitness within the ADF	Addressing stigma and barriers to care Strengthening the mental health screening continuum
Identification and response to mental health risks of military service	Improving pathways to care Developing e-mental health approaches Developing a comprehensive peer support network
Delivery of comprehensive, coordinated, customised mental health care	Improving pathways to care
Continuously improve the quality of mental health care	Enhancing service delivery Upskilling service providers
Building an evidence base about military mental health and wellbeing	
Strengthening strategic partnerships and strategic development	Strengthening the mental health screening continuum Enhancing service delivery

Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-15*, p. 11.

Requirement for ADF members to be 'medically fit'

3.9 Defence has an obligation to ensure that ADF member's duties do not detrimentally affect their health, that ADF members can undertake their duties without compromising the safety of themselves or others, and that the ADF as a whole maintains its operational capability. As outlined in the 2013 *Review of Health Information Practices in Defence*, Defence must balance the health of the individual ADF members with the effect that an individual's health issue may create within an operational situation:

The requirement that a member be fit for the performance of their duties is of paramount concern to the ADF. A member's employability and

11 Department of Defence, *Submission 34*, p. 3.

deployability goes to the very reason for being of the ADF; its operational capability. Members must be fit to undertake their duties without compromising the safety of themselves or others. Defence has an obligation to ensure that the undertaking of their duties does not have detrimental effects on the member's health. Accordingly the seeking of health treatment by a member, the provision of health treatment to the member by the Commonwealth, and, the requirement by the ADF that a member undergo a health examination or treatment, renders the provision of such a service as being outside the normally understood relationship of health practitioner and patient. The relationship becomes a 'three cornered' relationship with the ADF having a clear interest not only in the effect of a member's current health statement vis-à-vis the individual but also the greater effect that any health issue may create within an operational situation.¹²

3.10 The *Defence Act 1903* provides for regulations to be made in relation to medical treatment of ADF members and cadets. It is a condition of an ADF member's service that they be physically and mentally capable of performing the duties required of them and, if determined to be medically unfit (including unfitness because of incapacity due to mental ill-health), a member's service may be terminated under the provisions of the *Defence (Personnel) Regulations 2002*.¹³

3.11 ADF members may be ordered to submit to medical examination. Part 6 of the *Australian Military Regulations 1927* provides for compulsory medical examination of an Army member where directed by a superior officer to so attend, including the requirement that the member provide the person conducting the examination with all information and do anything required by the examiner for the purpose of such an examination.¹⁴ Part 4 of the *Air Force Regulations 1927* also provides that an Air Force member may be examined in a way approved by the Chief of Air Force to determine a member's level of medical fitness.¹⁵ The Navy operates similarly, however without such a legislative provision.¹⁶

Screening and early identification of mental ill-health

3.12 The Chief of the Defence Force stated that 'we are looking for early recognition of a mental health injury and then looking to get early rehabilitation to be able to get people back to work'.¹⁷ Defence advised the committee that it has implemented a comprehensive Mental Health Screening Program to identify and provide assistance to individuals who have been exposed to potentially traumatic

12 Department of Defence, *Review of Health Information Practices in Defence*, December 2013, pp 19–20.

13 Regulation 85(1)(b) if the member is an officer and regulation 87(1)(c) for an enlisted member.

14 Australian Military Regulation 433.

15 Air Force Regulation 433.

16 Department of Defence, *Review of Health Information Practices in Defence*, December 2013, pp 19–20.

17 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, *Committee Transcript*, 21 September 2015, p. 6.

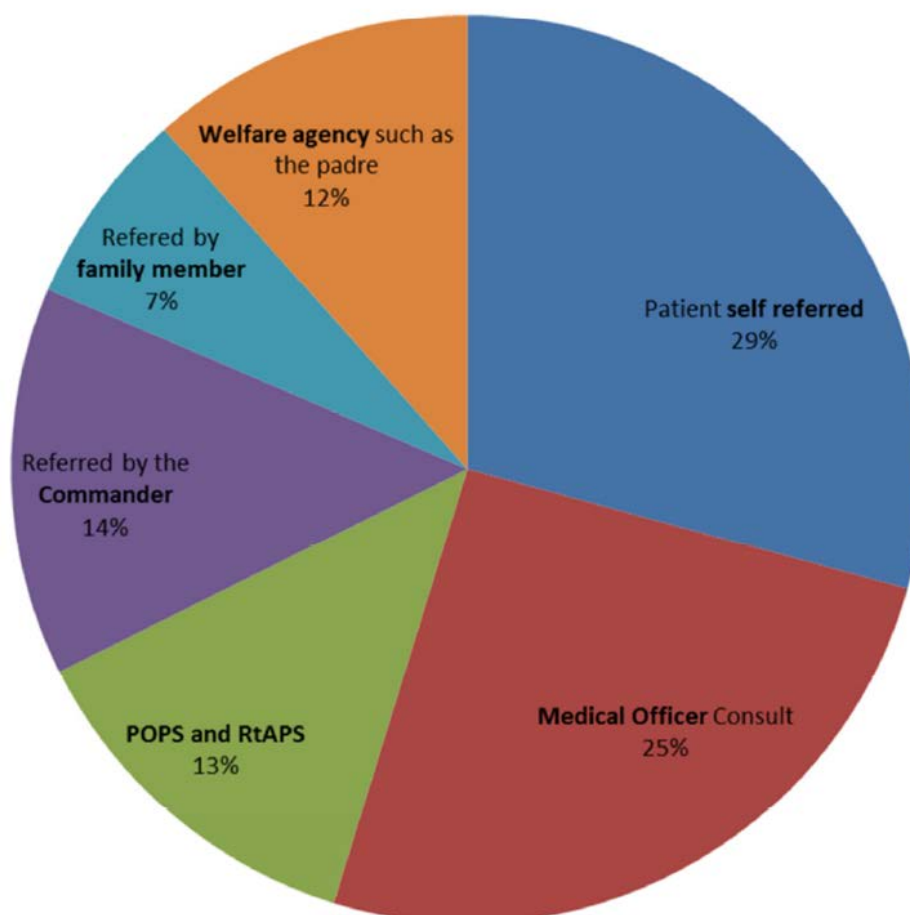
events through activities such as deployments, Border Protection operations, humanitarian and disaster relief missions or training accidents.¹⁸

Referral pathways

3.13 Aspen Medical found that the most common referral pathway for ADF members seeing a mental health professional was self-referral (29 per cent), closely followed by referral by a Medical Officer (25 per cent) (See Figure 3.1). Aspen Medical noted that this suggests that ADF mental health policy regarding the shared responsibility between commanders, individuals, and clinicians for the identification and early treatment of mental ill-health is working:

This success is evident in the high self-referral rate. It is possible that another person such as a commander, padre, family member or friend encouraged a patient to self-refer. However, the high rate of self-referral indicates that many individuals are willing to seek treatment. It also suggests that the stigmatism, once attached to [ADF members] mental health, is changing at the individual level.¹⁹

Figure 3.1 – Referral Pathway for Mental Health



Aspen Medical, *Submission 38*, p. 15.

18 Department of Defence, *Submission 34*, p. 4.

19 Aspen Medical, *Submission 38*, p. 15.

3.14 Some submissions questioned the effectiveness of screening in the early identification of mental ill-health.²⁰ Walking Wounded acknowledged that ADF mental health evaluation screening has 'improved markedly over recent years', but noted that it can be circumvented by ADF members who do not wish to be identified as struggling with mental ill-health:

The concept of post-operational psychological screening (POPS) is good but can often be "gamed" by soldiers who are keen to go on leave, etc, rather than be delayed by admitting to stress disorders. While not widespread, there are many who feel that once they go on leave, they will return to normal. Sadly, we know this isn't always the case.²¹

3.15 However, Dr Kieran Tranter informed the committee of a recent study, using participants from the MHPWS, which considered the diagnostic accuracy of the screening tests used by the ADF—the Kessler Psychological Distress Scale (K10), Alcohol Use Disorders Identification Test (AUDIT) and the Post-traumatic Checklist (PCL)—in a population-based military cohort.²² The study found that 'all three scales showed that good to excellent levels of overall diagnostic validity' and 'could sensitively detect disorder whilst maintaining good specificity'.²³

3.16 Aspen Medical noted that it has found that screening activities are 'useful at identifying early some [members] who need help'. Aspen Medical commented that the number of referrals to medical health professionals from Post Operational Psychological Screening and Return to Australia Psychological Screening indicates that screening is effective at early identification of deployed member's mental ill-health and that 'this suggests that the policy and conduct of these mandatory screens are achieving the effect that they were designed to achieve'.²⁴

3.17 Currently, there are a number of time points or key events that trigger mental health screening within the ADF, with approximately 8,000 members being screened every year. The majority of mental health screening is connected to deployment and after critical incidents. ADF member's participation in psychological screening, both on deployment and after returning from deployment, is mandated by each operation's Operational Health Support Plan (OHSP). Routine physical health checks, which occur every three to five years, also include an alcohol use screen.²⁵

20 For example: Mr Mark Keynes, *Submission 10*, p. 2; Walking Wounded, *Submission 18*, p. 3; Slater & Gordon, *Submission 51*, p. 7.

21 Walking Wounded, *Submission 18*, p. 3.

22 Dr Kieran Tranter, *Submission 27*, p. 17.

23 Amelia Searle et al, 'The Validity of Military Screening for Mental Health Problems: diagnostic accuracy of the PCL, K10 and AUDIT scales in an entire military population' *International Journal of Methods in Psychiatric Research*, Vol. 24, No. 1, p. 41.

24 Aspen Medical, *Submission 38*, p. 16.

25 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 30.

3.18 Defence advised that mental health support and screening may also be tailored to meet the requirements of a particular operation, giving the example of the program for Operation RESOLUTE, which aims to provide psychoeducation, surveillance and early identification and referral of members who require follow-up mental health support.²⁶

Types of screens

Return to Australia Psychological Screening (RtAPS)

3.19 Return to Australia Psychological Screening (RtAPS) is provided to all deployed ADF members nearing the end of their deployment. The aims of the RtAPS are to document traumatic exposure; document and manage current psychological status; provide advice and education to facilitate a smooth post-deployment transition; and provide information to Command on the psychological health of the deployed force. Further, in addition to identifying individuals at risk and arranging referral for more detailed assessment, the data gained from the RtAPS is used by the senior psychologist to brief the deployed element commander and to enable trend analysis.²⁷ The RtAPS comprises:

- group psycho-education brief on:
 - the RtAPS and its aims and process (including confidentiality issues and data use);
 - readjustment to family life (including reactions of partner, children, and friends);
 - readjustment to work (including relationships with peers and career decisions); and
 - health issues (including post-deployment fitness, and tobacco and alcohol use).
- a questionnaire, comprising the:
 - Deployment Experiences Questionnaire (including data on operational temp and unit climate);
 - Kessler Psychological Distress Scale (K10);
 - Traumatic Stress Exposure Scale – Revised (TSES–R);
 - Major Stressors Inventory – Revised (MSI–R); and the
 - Posttraumatic Checklist (PCL).
- one-on-one semi-structured screening interview, which covers the following (as a minimum):
 - introduction;

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

27 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 31–32.

- deployment experiences;
- potentially traumatic events;
- coping strategies;
- current symptoms;
- homecoming and adjustment issues;
- screening questionnaire summary; and
- psychoeducation.²⁸

Post-Operational Psychological Screening (POPS)

3.20 Post Operational Psychological Screening (POPS) is mandatory for all ADF members who were eligible to receive RtAPS (regardless of whether they did or not) and is usually conducted within three to six months of a member's return to Australia from an overseas deployment. The POPS process aims to identify individuals who have not reintegrated into occupational, familial, or social functioning and/or are demonstrating signs of adverse post-trauma responses. The POPS questionnaires and write-up are placed on the ADF member's psychology file and Unit Medical Record. The POPS process comprises:

- a questionnaire, comprising the:
 - Kessler Psychological Distress Scale (K10);
 - Posttraumatic Checklist (PCL);
 - Alcohol Use Disorders Identification Test (AUDIT); and
 - additional Command and research questionnaires as approved by the senior psychology asset for the services.
- a one-on-one semi-structured psychological screening interview that includes:
 - introduction;
 - review of the member's deployment experience;
 - homecoming;
 - reintegration;
 - current symptoms; and
 - psychoeducation.²⁹

28 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 31–32.

29 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 32–33.

Special Psychological Screen (SPS)

3.21 A Special Psychological Screen (SPS) may be provided to individuals and groups 'whose operational role routinely exposes them to intense operational stressors, critical incidents, and/or potentially traumatic events while on deployment'. The aim of the SPS is to aid the monitoring of the mental health status of such individuals and groups. The SPS may be administered regularly (every two to three months) and comprises:

- a psycho-educational briefing;
- a questionnaire comprising the:
 - Kessler Psychological Distress Scale (K10); and the
 - Acute Stress Disorder Scale (ASDS); and
- a one-on-one psychological screening interview.³⁰

3.22 The need for SPS is negotiated between commanders and mental health professionals, and the completion of SPS does not negate the necessity for RtAPS or POPS. Furthermore, the SPS can only be conducted by a mental health professional.³¹

Critical Incident Mental Health Support (CIMHS)

3.23 Critical Incident Mental Health Support (CIMHS) is initiated when a 'critical incident' has occurred, such as deployed members being exposed to potentially traumatic events.³² The activation and timing of the CIMHS is determined by the Commanding Officer in consultation with the CIMHS coordinator (the most senior CIMHS-trained mental health professional available). The CIMHS process comprises a number of activities across three stages:

- provision of social support, and psychological first aid (PFA) if necessary;
- provision of psychoeducation and administration of psychological screens (Acute Distress Disorder Scale and Mental Status Examination) to facilitate the identification of individuals at risk of psychological injury and initiation of referral for further assessment and treatment;
- follow-up (Kessler Psychological Distress Scale (K10), Posttraumatic Checklist (PCL) and Alcohol Use Disorders Identification Test (AUDIT)).³³

3.24 The timing of the follow-ups generally take place between three and six months after the initial screen. According to the CIMHS database, a total of 354

30 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 33–34.

31 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p.34.

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

33 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 34.

individuals received a CIMHS initial screen between March 2012 and March 2014, with the majority of those 354 individuals also having completed a follow-up screen.³⁴

Informal screening

3.25 The Australian Defence Force Mental Health Screening Continuum Framework Report (MHSCF Report), conducted by the Australian Centre for Posttraumatic Mental Health in 2014, highlighted the importance of informal screening for mental ill-health and noted that formal screening is not intended to replace informal processes, but rather, to complement them:

These informal processes may include families, friends, and peers helping the member identify that he or she has a problem. This type of informal screening is of great relevance in organisations such as the ADF that place a high emphasis on "looking after your mates". A commander, manager, or representative can also order a member to undergo psychological assessment or gain psychological support through administrative referral. Additionally, a Medical Officer (MO) can refer a member for psychological support or assessment through medical referral. Of course, members may also self-identify that they are experiencing mental health difficulties and request assistance. These informational processes of identifying members who are struggling with psychological adjustment issues are of primary importance in early detection and access to care.³⁵

3.26 Aspen Medical emphasised the importance of maintaining multiple ways to identify and bring ADF members to treatment, noting that 'the multi-faceted strategy taken by the ADF appears to be working'. It noted that in the ADF 'if one method does not identify a case an alternative method is highly likely to'.³⁶

Family involvement in identification and screening

3.27 The importance of involving the ADF member's family in the identification and treatment of mental ill-health was raised by a number of submissions.³⁷ Australian Families of the Military Research and Support Foundation (AFOM) asserted that families of ADF members are often the first to become aware of signs of mental ill-health and called for family to be involved in post-deployment screening processes.³⁸

3.28 Aspen Medical noted that its practitioners strongly supported greater involvement of a supportive family member in the treatment of mental health

34 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 33–34.

35 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, pp 16–17.

36 Aspen Medical, *Submission 38*, p. 16.

37 For example: Returned & Services League of Australia, *Submission 19*, p. 8; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 7; Aspen Medical, *Submission 38*, p. 85; Slater & Gordon, *Submission 51*, p. 21; Name withheld, *Submission 70*, pp 9–10. Australian Association of Social Workers, *Submission 77*, p. 3.

38 Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 7.

conditions for ADF members.³⁹ Furthermore, it found that seven per cent of referrals for ADF members to mental health professionals were from a member's family, commenting that 'the involvement of family also suggests that the ADF and JHC messaging to members' partners, spouses and the broader community are having an effect'.⁴⁰

3.29 The Australian Association of Social Workers highlighted the importance of family involvement and assessment of family dynamics in the identification and assessment of mental ill-health, noting that 'without a clear understanding of family dynamics, including stresses and strengths, mental health assessments will miss important information relevant for treatment and counselling outcomes':

An early family assessment is not only crucial in understanding the impact of a psychological diagnosis on the service personnel and their family, but also means that important supports can be mobilised early. It also alerts the clinician of areas in which clinical treatment might be undermined by family dynamics. Often treatment is disrupted by events in the external environment. Social work assessments that include a family assessment and an assessment of other psychosocial factors are highly valued in mental health teams.⁴¹

3.30 In 2011, the Family Sensitive Post Operational Psychology Screens (FSPOPS) were trialled with Mentoring Taskforce-2 (MTF-2) in Darwin and with MTF-3 in Townsville in 2012. The FSPOPS project involved training Defence psychology staff in family sensitive practices that can be applied to the POPS process. ADF members undertaking their POPS in Darwin and Townsville were invited to bring an adult family member to their POPS to 'provide an opportunity to discuss issues and challenges that may arise post-deployment'. This opportunity was promoted by Regional Mental Health Teams and Command elements.⁴²

3.31 Defence informed the committee that only a very small number of the hundreds of ADF members deployed with MTF-2 and MTF-3 brought family members to their POPS during the trial period. The majority of ADF members who did not bring a family member to their POPS indicated that they 'felt no issues existed that warranted discussion with a family member' or 'simply did not want to bring a family member'. However, those family members who did participate indicated that the experience was 'very good' and that they would participate again if offered.⁴³

3.32 Defence advised that the outcome of the trial 'suggests that this initiative was not one that appealed to the wider ADF audience' and that, as such, the trial was not

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

40 Aspen Medical, *Submission 38*, p. 16.

41 Australian Association of Social Workers, *Submission 77*, p. 3.

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

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

extended or developed into business as usual. However, Defence assured the committee that it remains committed to a family sensitive approach to screening and mental health and rehabilitation service delivery:

The trial has not been extended or developed into business as usual, but the concept of ensuring that family related matters and family sensitive questions are raised during Post Operational Psychology Screens by psychology staff has been adopted. This has resulted in a more family focussed approach to operational mental health screening of ADF members.

Defence recognises the importance of engagement with and support to families of members who are ill or injured. Defence is focusing on developing services and processes that support a family sensitive approach to mental health and rehabilitation service delivery, to promote positive outcomes for members and families. These processes include inviting family attendance at health assessments (where appropriate and with member consent), inviting attendance at psychosocial workshops and information sessions, and referral to available programs and services as appropriate. Resources available to family members are also reinforced through unit family days and direct communications from support services such a Defence Community Organisation or Veterans and Veterans Families Counselling Service.⁴⁴

Privacy

3.33 Some submissions noted that, linked to the stigma associated with mental ill-health, many ADF members were not comfortable disclosing mental health issues due to concerns that their privacy would not be respected and they would be subject to ridicule.⁴⁵ The Australia Psychological Society noted that:

Members report that stigmatisation may occur during service within the immediate base community and the larger organisation. This stigma and issues with confidentiality reportedly create difficulties particularly at the lower level of command where information about confidential disclosures [of mental ill-health] reportedly is disclosed to others in the base community.⁴⁶

3.34 Defence assured the committee that it is required to comply with the provisions of the *Privacy Act 1988* (Privacy Act) and the Australian Privacy Principles. Health Directive 610 *Privacy of health information of Defence members and Defence candidates* outlines the policy regarding the collection, use, and disclosure of health information in Defence by health professionals, commanders, managers, and members. A Health Information Privacy Notice, which details how

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

45 For example: Australian Psychological Society, *Submission 22*, p. 9; Mr Jeremy Davey, *Submission 25*, p. 4; Young and Well Cooperative Research Centre, *Submission 62*, p. 3; Dr Kevin Kraushaar, *Submission 64*, p. 10.

46 Australian Psychological Society, *Submission 22*, p. 9.

health information is collected, used, and disclosed, is available to all ADF members on the Defence Intranet.⁴⁷

3.35 ADF members must give consent for their personal health information to be used or disclosed in all but exceptional circumstances (as defined by the Australian Privacy Principles).⁴⁸ Exceptional circumstances include when use or disclosure is necessary to lessen or prevent a serious threat to an ADF member's life, health, or safety; or a serious threat to public health or public safety, including in military workplaces and safety critical areas such as deployment.⁴⁹

3.36 Defence informed the committee that health information is primarily collected by Defence health practitioners 'in order to clinically manage and treat a Defence member's health on an ongoing basis'. This health information is shared between all treating health professionals in order to provide coordinated health care services, particularly when ADF personnel are receiving mental health care. Health information can also be shared with external health care providers with the consent of the ADF member.⁵⁰

3.37 Defence stated that Defence health professionals are obliged to keep commanders and managers informed of the health status of ADF personnel to enable them to manage the workplace and operational impact of an ADF member's health condition. The health information provided is limited to information 'that enables a member's administrative management to be coordinated with their health support and rehabilitation management plans', unless the ADF member consents to more information being provided.⁵¹

Commanders' need to know and members' right to privacy

3.38 Some submissions highlighted the conflict between commanders' need to know about the mental health of their personnel and ADF members' right to privacy.⁵² The Inspector General of the Australia Defence Force (IGADF) noted that compliance with Privacy Act requirements and the confidentiality obligations of members of the medical profession can 'sometimes impede the reasonable sharing of medical and psychological information concerning a member that may be important for their better management by their chain of command or other Defence agencies with responsibilities for members' welfare and safety'.⁵³

47 Department of Defence, *Submission 34*, pp 7–8.

48 *Privacy Act 1988*, Sch. 1.

49 Department of Defence, *Submission 34*, p. 8.

50 Department of Defence, *Submission 34*, p. 8.

51 Department of Defence, *Submission 34*, p. 8.

52 For example: Inspector General of the Australian Defence Force, *Submission 15*, p. 1; Alliance of Defence Service Organisations, *Submission 40*, pp 11–12; Australian Peacekeeper & Peacemaker Veterans' Association, *Submission 78*, p. 3.

53 Inspector General of the Australian Defence Force, *Submission 15*, p. 1.

3.39 The Alliance of Defence Service Organisations (ADSO) asserted that commanders 'should surely have the right to know, and medical professionals the right to inform [them]', regarding any medical (mental or physical) problems that could compromise a mission or the safety of other ADF members. Further, the ADSO called for the application of the Privacy Act, as it applies to ADF members, to be reviewed:

The bargain struck between the ADF and the individual should be that the ADF provides comprehensive health care free of charge because it has to have a solid base of confidence that the individual meets the fitness standards demanded by the mission. This should mean that the individual surrenders that part of the right to privacy that is relevant to the mission, as he does in other areas, such as military security. Indeed it could be argued that physical and mental fitness is, at least in part, a security matter. ADSO urges that this aspect of the application of the Privacy Act to members of the ADF to be reviewed as a matter of urgency.⁵⁴

3.40 The IGADF advised the committee that some ADF members will choose to seek assistance from sources outside of the ADF for mental ill-health to prevent the chain of command from accessing information about the member's mental health. Such members fear putting their career, job categorisation, or deployment opportunities at risk. The IGADF described this as a 'catch-22 situation for Defence', for any attempts to relax patient confidentiality requirements to better identify and address mental ill-health might further discourage members from seeking assistance/treatment for mental ill-health within the ADF:

...the reluctance of some members who are aware they may have a medical or mental health problem to advise their chain of command or seek help from Service health authorities for fear of putting their career, job categorisation, or deployment opportunities in jeopardy. This can sometimes create a catch-22 situation for Defence where members may be minded to seek assistance from private sources in order to preserve confidentiality of their condition. The catch-22 arises where any relaxing of patient confidentiality requirements within Defence might potentially have the unintended effect of encouraging members to seek help outside the Service system.⁵⁵

3.41 The RSL also commented on ADF members' reluctance to disclosing mental health concerns, noting that some members choose not to disclose symptoms to avoid medical downgrading, which may interfere with their deployment or result in discharge. The RSL stated that 'members are well aware of the financial incentives associated with deployment and the need to be physically fit and mentally fit to deploy'.⁵⁶ The RSL, pointing to an opinion expressed in an interview with Dr Andrew Khoo, asserted that:

54 Alliance of Defence Service Organisations, *Submission 40*, pp 11–12.

55 Inspector General of the Australian Defence Force, *Submission 15*, pp 1–2.

56 Returned & Services League of Australia, *Submission 19*, p. 7.

...encouraging Defence members to seek early treatment for mental ill-health will not be successful until Defence allows members to be treated and continue in their career with Defence. Until then, serving members will continue to believe disclosure of mental ill-health will threaten their Defence career.⁵⁷

3.42 Defence acknowledged that there are times when 'despite all the best efforts on rehabilitation...people will end up inevitably being discharged',⁵⁸ but that 'of the 869 individuals with a mental illness who completed a rehabilitation program, a total of 420 or 52 per cent are recorded as having a successful return to work at the end of their rehabilitation program'.⁵⁹

3.43 The adequacy of mental health services is discussed in greater detail in Chapter 4 of this report. Stigma surrounding mental health and other barriers to disclosure is discussed in greater detail in Chapter 5.

Family access to members and veterans mental health records

3.44 Slater & Gordon Lawyers called for a review of the Privacy Act, asserting that details of mental health records should be released to families if the ADF member or veteran presents symptoms of mental illness that pose an immediate risk to personal safety, such as self-harm and suicide attempts.

In such situations, the ADF must have the authority to release certain details of a serviceman or woman's mental health record to their families in order for them to assist in providing support...the Committee must do everything in its power to ensure that families do not have to endure the heartbreak of losing a loved one from a potentially treatable mental illness.⁶⁰

3.45 Slater & Gordon pointed to the family of 27 year-old Navy Sailor Stuart Addison, who took his own life in 2002. His family have been campaigning for the next of kin to be contacted immediately by a member's commanding officer in circumstances where suicide attempts or self-harm is evident.⁶¹

3.46 One submitter called for families to be notified of suicide attempts. The submitter told the committee of their experiences strugglingly with mental ill-health and suicide, stating that their first attempted suicide took place while still a serving

57 Returned & Services League of Australia, *Submission 19*, p. 7.

58 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, Department of Defence, *Committee Hansard*, pp 7–8.

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

60 Slater & Gordon, *Submission 51*, p. 21.

61 Mark Addison, 'Malcolm Turnbull: we lost our son to suicide while serving in the ADF – please change service contracts so next-of-kin can be notified of self-harm, suicide attempts', <https://www.change.org/p/malcolm-turnbull-we-lost-our-son-to-suicide-while-serving-in-the-ADF-please-change-service-contracts-so-next-of-kin-can-be-notified-of-self-harm-suicide-attempts>, accessed 22 January 2016.

member. The submitter noted that 'suicide prevention takes inside information' and called for the introduction of a 'Family in Crisis Action Plan' to be triggered in the case of a suicide attempt:

...when a Veteran attempts Suicide, that contact is immediately made with the Veteran Family. Implementation of an Action Plan should include ESO Contact, Family Social Worker Contact to be able to assist any needs of the family during the Crisis. Also emergency Crisis care for children should be initialised and paid for by DVA whilst the Veteran is hospitalised and in treatment so that the partner or designated carer or eldest child can participate in the support and information process with the Veteran. "It must not be a journey taken alone by the Veteran."⁶²

3.47 Defence acknowledged these concerns but asserted that its focus is on ensuring ADF members are 'afforded appropriate privacy protections' while encouraging them to involve families and support networks in their mental health safety plan, treatment and recovery:

Defence recognises that there have been concerns expressed by family members about what information can be disclosed to them and how disclosing certain health information could have resulted in better mental health outcomes, or in extreme situations prevented a death by suicide. Defence's focus is on ensuring that ADF personnel are afforded appropriate privacy protections while encouraging the member to involve their families and support networks in their mental health safety plan, treatment and recovery by sharing their health information should they wish to do so.⁶³

Recordkeeping for ADF members

3.48 Defence informed the committee that 'health-related record keeping is managed in accordance with the Defence Records Management Policy and the relevant legislation'. Defence also advised that it is currently reviewing its health records management policy to provide a 'single policy for all ADF personnel that receive health services from Defence'.⁶⁴ However, the management of ADF mental health records has been criticised for a number of decades and have been the subject of a number of inquiries and audits.⁶⁵

62 Name withheld, *Submission 70*, pp 9–10.

63 Department of Defence, *Submission 34*, p. 8.

64 Department of Defence, *Submission 34*, p. 9.

65 For example: Department of Defence, *Devolution and integration in the Australian Defence Force: the Defence Regional Support Review*, 1989; Australian National Audit Office, Audit Report No.34 (1996–97), *Australian Defence Force Health Services*; Department of Defence, *Future directions for the management of Australia's defence—Report of the Defence Efficiency Review*, 1997; Australian National Audit Office, Audit Report No.51 (2000–2001), *Australian Defence Force Health Services Follow-up Audit; Review of Defence Health Services*, 2004; Department of Defence, *Healthcare in the Australian Defence Force*, 2008; Senate Foreign Affairs, Defence and Trade References Committee, *Australia's Involvement in Peacekeeping Duties*; and Professor David Dunt, *Review of Mental Health Care in the ADF and Transition through Discharge*, January 2009.

3.49 The committee received a number of submissions commenting on the difficulties with accessing health records and the complications that can arise when a veteran is making a claim if health records are incomplete or inaccurate.⁶⁶ Furthermore, comprehensive health records of veterans can be even more challenging, as noted by Mr Robert Shortridge: 'maintaining records of those ex-service personnel once they have left the ADF will be very difficult as there is no compulsion for them to identify themselves as ex-service personnel or veterans'.⁶⁷

3.50 Walking Wounded described ADF recordkeeping as a 'weak area', noting that, despite good recordkeeping policies, 'human error, tiredness, inattention and carelessness' lead to incidents being reported 'badly or not at all':

Anecdotally, all soldiers have stories of how a particular incident was recorded badly or not at all, including events where injuries occurred. This often leaves the record incomplete or disjointed, particularly where operational imperatives take precedence. In addition, the retrieval of records pertaining to a specific incident some years in the past is often almost impossible, owing to personnel turnover and the reasons cited above. When an ADF member is no longer an ADF member, the task gains a further degree of difficulty.⁶⁸

3.51 One submitter noted that a complete and accurate record of a member's mental health is dependent on the member disclosing their mental ill-health, something that many may be reluctant to do.⁶⁹

Defence e-Health System

3.52 In 2009, Defence launched the Defence eHealth System (DeHS) (originally called the Joint eHealth Data and Information System). The key features of the DeHS include:

- Primary Care System (PCS): an eHealth care system used to record all clinical, dental, mental health, and allied health consultations, treatments and findings;
- DeHS Access: an online patient- accessible summary of each patient's eHealth record; and
- DeHS Reporting: a suite of reporting tools available to report on individual or corporate information requirements.⁷⁰

66 For example: Mr Douglas Steley, *Submission 6*, p. 15; Mr Robert Shortridge, *Submission 16*, p. 5; Walking Wounded, *Submission 18*, pp 2–3; Soldier On, *Submission 29*, p. 6; Aspen Medical, *Submission 38*, p. 20; Slater & Gordon Lawyers, *Submission 51*, pp 7–10; Name withheld, *Submission 56*, pp 2–3; KCI Lawyers, *Submission 71*, pp 4–5.

67 Mr Robert Shortridge, *Submission 16*, p. 7.

68 Walking Wounded, *Submission 18*, pp 2–3.

69 Name withheld, *Submission 56*, p. 2.

70 Australian National Audit Office, Audit Report No. 27 2014-15, *Electronic Health Records for Defence Personnel*, 2015, p. 29.

3.53 These three features are intended to provide a clinical management tool 'that enables safe and quality health care for the ADF member'. The DeHS business case noted that the system would:

- inform ADF Commanders of the readiness for operational deployments of individuals and Force Elements;
- contribute to the generation of health performance and work health and safety metrics to support the management of resources as well as planning and accountability; and
- provide for effective health management after an ADF member's discharge by facilitating the transfer or access of an ADF member's health record by DVA as part of ongoing care and/or to inform compensation determinations.⁷¹

3.54 Furthermore, the DeHS is intended to complement the civilian National e-Health Strategy and link with the national Personally Controlled Electronic Health Record:

The Joint eHealth Data and Information (JeHDI) Project [now called DeHS] will facilitate the provision of one electronic health record for ADG personnel, from recruitment to discharge, then through to management in other agencies...[DeHS] is building the capability to interact with the National Personal Controlled Electronic Health Record (PCEHR) for the interchange of health information across private and public health systems. Members will be able to consent to participation in the PCEHR system while in Defence or when they discharge.⁷²

3.55 Defence advised that the DeHS was implemented within all Joint Health Command Garrison health centres on 11 December 2014 and that the DeHS project to implement the system on-board ships is scheduled for implementation on the "First of Fleet" by June 2016, with subsequent roll out to the remainder of the fleet in accordance with the Fleet schedule.⁷³

3.56 Defence informed the committee that it is expected that ADF members will be able to access their e-Health record via the internet portal from the second-half of 2015. ADF members will be able to view a summary of their health record, view recent and scheduled appointments, and complete health questionnaires in preparation for a mental health consultation. ADF members will be able to access routine mental health questionnaires and screening tools online, which, Defence advised, will notify mental health professionals if the results of a questionnaire need to be responded to urgently.⁷⁴

71 Australian National Audit Office, Audit Report No. 27 2014-15, *Electronic Health Records for Defence Personnel*, 2015, p. 29.

72 Department of Defence, answer to question on notice, 12 June 2012, (received 29 September 2012).

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

74 Department of Defence, *Submission 34*, p. 10.

3.57 Defence explained that the data analysis and reporting functions of DeHS will allow Defence to 'target reporting for specific mental health presentations and disorders and that the DeHS system has minimised the use of paper records, with the majority of ADF members receiving primary health care treatment through a Garrison Health Organisation'. All mental health and psychology records created prior to the implementation of DeHS will continue to be available. In addition, as legacy systems are decommissioned, all pertinent records will be transferred to Objective (the approved restricted Defence electronics records management system).⁷⁵

3.58 Aspen Medical reported that it received a number of positive comments in its initial survey regarding the benefits of the new DeHS, with 39 per cent of respondents agreeing that the DeHS has improved the availability of relevant documents and only 18 per cent disagreeing or strongly disagreeing. Aspen Medical noted that many positive comments also expressed a degree to frustration with DeHS.⁷⁶

Hospital admissions, external referrals, and fatalities

3.59 Defence explained that the DeHS incorporates ADF members' external mental health provider reports, ensuring that a member's health record reflects a continuous view of their mental health care that can be monitored by Defence:

The Defence e-Health System allows for the timely monitoring of external mental health provider reports by the local Mental Health and Psychology Section, and these reports are reviewed at the regular multidisciplinary Case Review meetings to ensure that treatment is meeting the needs of the member, and that the member remains engaged with the external provider. The external reports are then electronically appended to the member's health record via Defence e-Health System in order to provide a continuous view of the member's mental health care.⁷⁷

3.60 If an ADF member requires admission to an external treatment facility as an inpatient, either as an emergency or planned admission, the referral is noted in the member's e-Health record and a Notification of a Casualty (NOTICAS) and a Medical Casualty (MEDICAS) are raised. The NOTICAS and MEDICAS notifications allow command, health, and welfare agencies to ensure that the member's occupational, health, and domestic needs are met and that the member's family is supported during the admission. Once discharged, a discharge summary report is provided to the treating garrison health facility and uploaded into DeHS. Defence advised that the admission of an ADF member to an external treatment facility for mental health inpatient treatment is regularly followed up by the local Mental Health and Psychology Section.⁷⁸

3.61 Defence advised that, following the death of a serving ADF member, the e-Health record is moved from the DeHS to Objective, the approved restricted Defence

75 Department of Defence, *Submission 34*, p. 9.

76 Aspen Medical, *Submission 38*, p. 52.

77 Department of Defence, *Submission 34*, p. 10.

78 Department of Defence, *Submission 34*, p. 10.

electronic record management system for archival purposes. The archived record can be accessed by Defence health care professionals and member's families can request access 'using normal Defence record access request processes'.⁷⁹

Suspected or confirmed suicide

3.62 Defence informed the committee that the release of post mortem results and coronial inquiry outcomes remains at the discretion of the coroner and are not routinely provided to Defence unless pursued by the ADF Investigative Service. Defence noted that post mortem updates can be made to an ADF member's DeHS record upon receipt of a death certificate or coronial record but that this is not mandated:

Clinicians do not currently update the record regarding speculative diagnosis or causal finding. The finding of suicide has to be a post mortem update and this is permitted to be added to the record by authorised users. The content of these updates/entries are not mandated in any way. If Defence does receive a death certificate or coronial record it will be added to the record.⁸⁰

3.63 Defence advised that Joint Health Command maintains a database, separate to the DeHS, of suspected or confirmed deaths as a result of suicide since 1 January 2000. Suspected or confirmed deaths as a result of suicide are included in the database on the advice of the ADF Investigative Service and/or the findings of State/Territory Coroner Reports.⁸¹

Medical records during deployment

3.64 Aspen Medical reported that that it 'is rarely easy to find relevant clinical information collected or recorded in-theatre' regarding mental ill-health or potentially traumatic incidents:

Just over 75 per cent of respondents found that it is usually not easy to find clinical information on incidents that occurred in theatre. In many instances the trigger event for a mental health condition may not have an immediate impact on the [member], so in effect there is no clinical record of the event occurring.⁸²

3.65 Aspen Medical noted that some clinicians suggested that Medical Officers (MO) and Mental Health Professionals (MHP), when treating a member, should be given access to the member's commander when the traumatic event occurred which

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

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

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

82 Aspen Medical, *Submission 38*, p. 20.

might have caused mental health problems. This would allow the MO and MHP to understand the events without forcing the member to 'relive' them.⁸³

3.66 A number of submissions highlighted the importance of accurate and detailed records when lodging a claim with DVA.⁸⁴ This is discussed in greater detail in Chapter 5 of this report.

Identification and screening of mental ill-health during transition

3.67 The ADF does not currently conduct post-transition screening. The Defence Community Organisation emails a post-separation survey to all ADF members who have been discharged for at least three months. The post-separation survey asks questions regarding the separation experiences, the member's chosen post-transition occupation, and their perceptions of support received around transition.⁸⁵

3.68 The MHSCF Report noted that screening at discharge was challenging due to transitioning members' concerns that identification of mental health problems might delay their discharge:

During the discussions about timing, the process at transition was raised. Both senior leaders and health professionals noted that screening at transition was challenging as members may be concerned that identifying mental health problems may delay their discharge. There were some suggestions that, if screening were to be included in the transition process, it should occur around six months prior to transition in order to be able to address any concerns without the risk of delaying the member's leave.⁸⁶

3.69 Discharge and transition from the ADF to civilian life will be discussed in greater detail in Chapter 6 of this report.

Veteran Mental Health Strategy

3.70 The Department of Veterans' Affairs (DVA) is responsible for the development and implementation of programs to assist the veteran and defence force communities. It provides administrative support to the Repatriation Commission and the Military Rehabilitation and Compensation Commission. It is responsible for advising the Commissions regarding policies and programs for beneficiaries as well as for administering these policies and programs. Mr Shane Carmody, the Chief Operating Officer for DVA, advised the committee that mental health is a priority for DVA:

83 Aspen Medical, *Submission 38*, p. 20.

84 For example: Mr Douglas Steley, *Submission 6*, p. 15; Mr Robert Shortridge, *Submission 16*, p. 5; Walking Wounded, *Submission 18*, pp 2–3; Soldier On, *Submission 29*, p. 6; Aspen Medical, *Submission 38*, p. 20; Slater & Gordon Lawyers, *Submission 51*, pp 7–10; Name withheld, *Submission 56*, pp 2–3; KCI Lawyers, *Submission 71*, pp 4–5.

85 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 35.

86 Australian Centre for Posttraumatic Mental Health, *The Australian Defence Force Mental Health Screening Continuum Framework*, July 2014, p. 62.

Mental health is a priority for DVA and any suicide is a tragedy, so we must do all we can to prevent it. As the committee knows, funding for mental health treatment is demand-driven and is not capped. We spend around \$182 million annually on veteran mental health services, but our focus remains on early intervention. If people are worried about how they are feeling or how they are coping we encourage them to seek help early. There are services and there is support ready and waiting to help.⁸⁷

3.71 The *Veteran Mental Health Strategy 2013-2023* outlines the strategic framework to support the mental health and wellbeing of veterans. The strategy lists six strategic objectives to guide mental health policy and programs:

- ensure quality mental health care, which puts the client at the centre, is evidence-based, efficient, equitable, and timely;
- promote mental health and wellbeing, addressing the diverse needs of clients and barriers to help-seeking such as stigma;
- strengthen DVA workforce capacity, ensuring a strong understanding of military and ex-military experience, and knowledge of best practice mental health interventions;
- enable a recovery culture, reducing the stigma surrounding mental health in the veteran and ex-service community and encouraging help-seeking and support recovery;
- strengthen partnerships, leading to improved service systems, enhanced communication and coordination, efficient use of resources, and opportunities for continuous feedback and improvement; and
- build the evidence base, building capacity within the mental health provider community and informing policy and program development.⁸⁸

3.72 DVA described the focus of its mental health policy as 'firmly on early intervention':

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. Further, the Government is very focussed on improvements to reduce the time taken to process compensation claims, a key early initiative.⁸⁹

87 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 29 September 2015, p. 3.

88 Department of Veterans' Affairs, *Veteran Mental Health Strategy 2013-2023*, pp 34-44.

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

3.73 Mr Carmody reiterated this, stating that 'DVA's major focus is on early intervention. This is the critical step in identifying and meeting the mental health needs of the veteran community'.⁹⁰

Identification of mental ill-health in veterans

3.74 Unlike ADF members, veterans are not required to be screened for mental ill-health and veterans cannot be 'ordered' to seek treatment or assistance when they display symptoms of mental ill-health. However, veterans can access the *ADF Post-discharge GP Health Assessment*, a 'comprehensive health assessment from their General Practitioner (GP)'. The scheme provides GPs with screening tools for alcohol use, substance use, post-traumatic stress disorder (PTSD) and psychological distress 'to help GPs identify and diagnose the early onset of physical and/or mental health problems'. The scheme is funded under the health assessment items on the Medicare Benefits Schedule.⁹¹

3.75 Generally, DVA is made aware of a veteran's mental ill-health once a veteran has lodged a claim. A number of submissions noted that this puts the impetus for recognising and seeking treatment for mental ill-health on the veteran.⁹² Walking Wounded commented that 'once a Defence member leaves the service, the responsibility for overarching care falls foremost onto the individual and, if he or she is lucky, close family members'.⁹³ The Australian Psychological Society described this as a critical barrier to identifying the scope of veterans' health needs:

Post discharge, veterans are unable to be identified by DVA where they do not seek entitlements to pensions, compensation or treatment. This creates critical barriers to identifying the scope of service-related health and welfare issues and the demand for associated services. While DVA advocates that there should be service pathways which operate under the 'no wrong door policy' approach and maintains registration information about veterans and current serving personnel who seek entitlements, in the absence of such registration, there is little chance that ex-service personnel will seek or receive the DVA funded treatment to which they are entitled.⁹⁴

3.76 The Royal Australian Regiment Association (RARA) noted that 'many veterans leave the ADF without lodging any claims for disability but they develop problems later in life and who are, or consider themselves to be healthy, may feel a

90 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 29 September 2015, p. 2.

91 Department of Veterans' Affairs, *Submission 35*, p. 30; Department of Veterans' Affairs, 'At Ease: ADF Post-discharge GP Health Assessment' <http://at-ease.dva.gov.au/professionals/assess-and-treat/adf-post-discharge-gp-health-assessment/>, accessed 22 January 2016.

92 For example: Walking Wounded, *Submission 18*, p. 2; Veterans Care Association, *Submission 4*, pp 1–2; Returned & Services League of Australia, *Submission 19*, p. 3; Australian Psychological Society, *Submission 22*, p. 9; Soldier On, *Submission 29*, p. 5.

93 Walking Wounded, *Submission 18*, p. 2.

94 Australian Psychological Society, *Submission 22*, p. 9.

little embarrassed about seeking help'. The RARA asserted that 'DVA is the appropriate sponsor for embracing these people' and called for a review of the processes for identifying and monitoring veterans mental health:

There needs to be a major conversation and paradigm shift in the mindset of the Government and Parliament, Defence Department that includes DVA, veterans, and the broader community as to how we can best keep track of all our veterans well after their service and not just those who have become DVA clients.⁹⁵

3.77 The RSL also noted that many veterans are reluctant to respond to early symptoms of mental ill-health, stating that 'ignoring symptoms and not seeking help can sometimes go on for eight to 10 years after discharge':

We are told by many veterans and their families that symptoms are ignored for a variety of reasons, including pride, learned responses in Defence to ignore emotions and keep going, the financial incentives associated with deployment, a belief that they are not the problem, and a lack of knowledge of the symptoms of mental ill-health.⁹⁶

3.78 DVA acknowledged these concerns, noting that 'the challenge for DVA is to encourage clients to seek help early if they are worried about how they are coping or feeling, and not wait until the symptoms become overwhelming'.⁹⁷ Mr Carmody advised the committee that DVA is working to raise awareness of its services, assisting transitioning members, and encouraging the early lodgement of claims:

To ensure that people know about our services and the support that we can provide, the department secretary now writes to all 6,000 or so ADF personnel who separate each year. This letter outlines what DVA can do for them and that we are here to help them if and when required. Even so, around 25 per cent of separating ADF personnel opt out of receiving information from DVA. DVA's on-base advisory service has developed into a very important service, providing advice and support as well as encouraging the early lodgement of claims. DVA now has an on-base presence at over 44 bases around the country. In 2013-14, our on-base service responded to over 13½ thousand inquiries—an increase of over 4½ thousand on the previous year.⁹⁸

3.79 DVA asserted that it is using 'new and innovative ways' to reach out to contemporary veterans and encourage them to take action early to address any mental health concerns. DVA provides a single mental health online portal, known as 'At Ease', which brings together all of its online products. These include: self-help and

95 Royal Australian Regiment Association, *Submission 46*, pp 1–2.

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

97 Department of Veterans' Affairs, *Submission 35*, p. 6.

98 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 2.

supportive phone apps; videos of veterans talking about their mental health recovery; and information about professional support and treatment options.⁹⁹

3.80 DVA advised that it also works in partnership with the ex-service community to implement health and wellbeing programs, which focus on seeking help when needed and healthy lifestyle behaviours such as healthy eating, social connectedness and physical activities.¹⁰⁰ The RSL stated that it is working together with DVA and other ex-service organisations (ESOs) to reach out to veterans who are struggling with mental ill-health:

The RSL, other Ex-Service Organisations (ESOs) and DVA are working hard to 'pick up the pieces' and intervene as soon as anyone in difficulty is brought to our attention. Informal networks of support, both face-to-face and online are extensive. There is a collective goodwill and concern for mates that characterises this sector (among both current and ex-serving members) and together many veterans have saved the lives of others in trouble.¹⁰¹

3.81 However, the RSL warned that 'relying on informal networks alone can be fraught with potential problems'.¹⁰²

Veterans identification system

3.82 The RARA and the Alliance of Defence Service Organisations called for the introduction of a veteran identification number or identification card to assist in the collection of data regarding the health and wellbeing of veterans who are not DVA clients.¹⁰³ The RARA noted that:

In recent times, the media has highlighted the incidence of veterans being incarcerated and sadly self-harm and suicide. These three issues raise the possibility that many of the homeless, veterans in the prison system and self-harm are invariably in this state due to mental health issues. Too many veterans are falling through "the cracks" because we don't know who or where they are.¹⁰⁴

3.83 The Veterans Care Association noted that the provision of a veteran identification card would 'add dignity and honour the service of all veterans'.¹⁰⁵ The ADSO asserted that the introduction of a veteran identification card would allow support services such as medical, ambulance, police and government agencies to better identify veterans:

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

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

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

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

103 Alliance of Defence Service Organisations, *Submission 40*, pp 13–14; Royal Australian Regiment Association, *Submission 46*, pp 1–5.

104 Royal Australian Regiment Association, *Submission 46*, p. 1.

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

One of the principle requirements of support is being able to identify veterans. The need for a single identifier to follow and ADF through service and into post ADF life is becoming more evident. It has the support of the AMA [Australian Medical Association]. It should cover all serving and former ADF members.

A National Veteran Identity Card could fulfil this need and would allow support agencies (medical, ambulance, police, government agencies, etc.) to identify and allocate veterans to the appropriate assistance needed.¹⁰⁶

3.84 Mr Carmody advised the committee that DVA is working with Defence to implement a single identification number but that there are a number of complications including non-ADF DVA clients (such as war widows) and privacy issues:

We are also trying to work with Defence on this single number but, as I have said, we have 340,000 clients and a large number of our clients do not have ADF service; they are war widows. So 60,000 to 70,000 people do not have a Defence number. We also have the situation where, particularly, our World War II and or Korean veterans had different prefixes on the numbers that they were allocated when they were in service, by state. There were different prefixes by gender. Our history of engagement with the numbering system is a very long one, and there is a range of very different numbers. We are in the process of working with Defence to try and resolve that in looking forward; however, in terms of all of our current client base, we need a very complex system of cross-referencing the various numbers that they might have been given, including DVA numbers. It is not a straightforward matter of just giving everyone a number, because as I said, a large number of our clients will not have one to start with.¹⁰⁷

3.85 The records required for DVA claims, and the systems under which these records are stored and accessed, is discussed in Chapter 5 of this report.

Committee view

3.86 The committee acknowledges the challenge of ensuring that ADF members' duties do not detrimentally affect their health; that ADF members can undertake their duties without compromising the safety of themselves or others; and that the ADF as a whole maintains its operational capability. The committee commends the ADF for its mental health and wellbeing strategy and acknowledges the significant achievements that it has made since the introduction of its first Mental Health Strategy in 2002. Early identification and treatment of mental ill-health is crucial for ADF members struggling with mental ill-health to achieve the best possible outcomes as well as ensuring that the ADF maintains operational capability.

106 Alliance of Defence Service Organisations, *Submission 40*, pp 13–14.

107 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 21.

Identification of mental ill-health in the ADF

3.87 The committee is satisfied that the RtAPS, POPS, SPS, and CIMHS screening processes, together with informal screening, are useful tools for the early identification of mental ill-health among ADF members who have been deployed. However, the committee is concerned that similar care is not taken to identify mental ill-health among ADF members who have not been deployed. As discussed in chapter 2 of this report, the findings of the MHPW study indicated that there is no significant link between deployment and an increased risk of developing PTSD, anxiety, depression or substance abuse disorders. Yet, despite this, mental health screening appears to focus primarily on identifying mental ill-health in members who have been deployed.

3.88 The committee is encouraged by the referral pathways reported by Aspen Medical and the high percentage of self referrals and referrals from medical officers, which indicate that mental health policy regarding the shared responsibility between commanders, individuals, and clinicians for the identification and early treatment of mental ill-health is working. However, the committee believes that regular formal and informal screening of ADF members, regardless of their deployment status, will improve the early identification and treatment of mental ill-health in the ADF.

3.89 The committee acknowledges that ADF members may be concerned about the potential impact that the discovery of mental ill-health may have on their careers. Nonetheless, the committee believes that the early identification and treatment of mental ill-health is significantly less likely to negatively impact a members' career, both within and beyond the ADF, than mental ill-health that is left untreated. Furthermore, annual screening would provide a regular opportunity for ADF members to pause and consider their mental health as well as providing a forum to express concerns that they might have without the member needing to initiate an appointment with their medical officer or psychologist.

Recommendation 1

3.90 The committee recommends that Defence conduct annual screening for mental ill-health for all ADF members.

Privacy and disclosure of mental ill-health

3.91 The committee acknowledges ADF members' right to privacy and the stigma and concerns regarding career prospects that might cause ADF members to conceal mental ill-health from their commanders and colleagues. However, the committee recognises that the ADF members' right to privacy must be carefully balanced with commanders' responsibilities to ensure that ADF members' duties do not detrimentally affect their health, that ADF members can undertake their duties without compromising the safety of themselves or others, and that the ADF as a whole maintains its operational capability.

3.92 The committee is satisfied that the provisions of the Privacy Act and the Australian Privacy Principles appropriately govern the collection, use, and disclosure of health information in the ADF. The committee notes the concerns raised by the IGADF and the calls from ADSO and Slater & Gordon Lawyers for the Privacy Act,

as it applies to ADF members, to be reconsidered. However, as the root of these concerns appears to be ADF members' reluctance to disclose mental ill-health, the committee does not believe that stricter disclosure laws or a lessening of ADF members' rights regarding privacy will assist in the early identification and treatment of mental ill-health. More effort should be given to addressing the stigma of mental ill-health in the ADF than tampering with privacy laws.

Recordkeeping

3.93 The committee commends the goals of the DeHS, which, once fully implemented and integrated with the civilian National e-Health Strategy, will provide ADF members and veterans with an accurate, easily accessible, and continuous health record. The committee also notes that Defence is currently undertaking a review of its health records management policies to consolidate a 'single policy for all ADF personnel that receive health services from Defence'.

3.94 Accurate health records are vital in ensuring that ADF members receive informed and targeted treatment for mental ill-health as well as being a crucial element in the DVA claims process. As such, the committee is concerned by evidence from medical officers and mental health professionals that it remains difficult to find relevant clinical information collected or recorded during deployment.

3.95 The committee acknowledges that there are a range of factors that can impact accurate recordkeeping, especially on deployment, and that accurate recordkeeping of ADF members' mental health may also be inhibited by reluctance to report mental ill-health. However, it is essential that mental ill-health and potentially traumatic events are accurately recorded during deployment and that medical officers and mental health professionals can easily access these records when treating ADF members. It is also important to ensure that veterans and DVA can easily and quickly access these records when assessing claims.

Recommendation 2

3.96 The committee recommends that the Australian National Audit Office conduct an audit into the scope and accuracy of recordkeeping of relevant clinical information collected or recorded during deployment regarding mental ill-health or potentially traumatic incidents.

Identification of mental ill-health in veterans

3.97 The committee commends DVA for its 'At Ease' online portal, which provides comprehensive information regarding mental ill-health to ADF members, veterans and their families. The committee recognises that veterans are private individuals who, unlike ADF members, cannot be ordered to undergo mental health screening or ordered to seek treatment or assistance when they display symptoms of mental ill-health. DVA is limited in its ability to identify or monitor mental ill-health in veterans to those veterans who have sought assistance or made a claim with DVA.

3.98 The committee acknowledges these limitations and notes the calls for DVA to monitor the health of veterans who have not made a claim. However, any move to monitor veterans without their consent would constitute a significant breach of privacy. Nonetheless, whilst engagement with DVA must be initiated by the veteran,

the committee acknowledges that more must be done to encourage veterans to seek assistance early and to make the process for seeking assistance simple and swift.

3.99 The committee is very concerned regarding the piecemeal identification systems for veterans; more must be done to ensure continuity of identification of veterans, regardless of whether they are clients of DVA. The committee acknowledges that DVA is working with Defence to implement a single identification number between the two departments, however the committee believes that all veterans should be provided with a universal identification number and identification card that can be linked to the veteran's service and medical records and utilised by both Defence and DVA, as well as other services such as the those offered by the Department of Health and Department of Human Services. All ADF members should be issued with a veteran identification number and identification card upon discharge. All current and future clients of DVA should be issued with this number and card and veterans who are not currently clients of DVA should be actively encouraged to register for the veteran identification number and identification card.

Recommendation 3

3.100 The committee recommends that all veterans be issued with a universal identification number and identification card that can be linked to their service and medical record.

3.101 The *ADF Post-discharge GP Health Assessment* scheme is an important tool for the early identification and treatment of mental ill-health; however it too relies on the veteran to initiate. The DeHS (once fully implemented and integrated with the civilian National e-Health Strategy) should provide veterans with an accurate, easily accessible, and continuous health record. This should ideally allow GPs and other health professionals to identify that their patient is a veteran as well as allowing them to view records regarding any mental ill-health concerns or exposures to potentially traumatic events that may have occurred during the veterans' service.

3.102 Furthermore, annual reminders through the e-health system prompting GPs to suggest the veteran undergo *ADF Post-discharge GP Health Assessment* would encourage veterans to engage with the scheme or even simply provide an opportunity for veterans to discuss any mental health concerns with their GP. In the meantime, GPs should be encouraged to promote the *ADF Post-discharge GP Health Assessment* to all veterans.

Recommendation 4

3.103 The committee recommends that the Department of Health and the Department of Veterans' Affairs ensure that e-health records identify veterans and that GPs are encouraged to promote annual *ADF Post-discharge GP Health Assessment* for all veterans.

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.¹ 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.²

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.³

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:

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.⁴

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'.⁵

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".⁶

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.⁷ 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.⁸

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'.⁹

Mefloquine neurotoxicity

4.9 The committee received evidence regarding the neuro-psychiatric effects of mefloquine hydrochloride (mefloquine)¹⁰, 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.¹¹ 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

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.¹²

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'.¹³ 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.¹⁴

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'.¹⁵

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

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'.¹⁶

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.¹⁷

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'.¹⁸

Moral injury

4.15 Some submissions highlighted the impact of 'moral injury' on ADF members' and veterans' mental health.¹⁹ 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

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.²⁰

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.²¹

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.²²

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

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.²³

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.²⁴

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'.²⁵

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'.²⁶ 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

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'.²⁷

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).²⁸

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.²⁹ 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'.³⁰

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'.³¹ 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'.³²

4.26 Some submitters did note that the quality of service was dependant on where ADF members were based.³³ 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.³⁴

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.³⁵

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.³⁶

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.³⁷

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'.³⁸

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.³⁹

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

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.

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

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.⁴¹ 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.⁴²

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.⁴³

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;

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;⁴⁴ 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.⁴⁵

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.⁴⁶

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

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'.⁴⁷ 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.⁴⁸ 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.⁴⁹

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.⁵⁰

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,

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'.⁵¹

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'.⁵²

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'.⁵³ 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.⁵⁴

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'.⁵⁵

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.⁵⁶

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'.⁵⁷

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.⁵⁸ 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'.⁵⁹ 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.⁶⁰

4.48 However, some submissions noted that many veterans may not be able to access these services.⁶¹ 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

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.⁶²

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.⁶³

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.⁶⁴

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.

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.
Total	178.6	

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.⁶⁵

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.⁶⁶

Schedule of fees for psychologists

4.54 The committee received evidence raising concerns regarding DVA funding schedules for mental health services.⁶⁷ 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.⁶⁸

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.⁶⁹ 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

DVA Item Number	Item description	DVA Fee*	APS recommended fee**
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

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.⁷⁰

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).⁷¹ 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'.⁷² 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.⁷³

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.⁷⁴

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'.⁷⁵ 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.⁷⁶

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.⁷⁷

Eligibility

4.62 A number of submissions raised concerns regarding the eligibility requirements for VVCS.⁷⁸ 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

75 Department of Veterans' Affairs, *Submission 35*, p. 42.

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

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

78 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.⁷⁹

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;

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.⁸⁰

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.⁸¹

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.⁸²

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'.⁸³

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'.⁸⁴

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.⁸⁵ 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.⁸⁶

4.69 Some submissions raised the importance of practical support for families struggling with mental ill-health, especially with regards to childcare.⁸⁷ 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.⁸⁸

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.⁸⁹

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.⁹⁰

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'.⁹¹

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

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.⁹²

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'.⁹³ 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.⁹⁴

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.

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.

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.

Chapter 5

Barriers to accessing mental health services

Introduction

5.1 This chapter considers the barriers to accessing mental health services for ADF members and veterans, primarily their reluctance to seek help. It also focuses on the difficulties and challenges experienced by ADF members and veterans in seeking assistance through Department of Veterans' Affairs (DVA) delivery models and claims processes, including ADF members and veterans who live in regional and remote areas.

Stigma and perceived barriers to care

ADF members

5.2 As discussed in previous chapters, both Defence and DVA agree that early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. However, the 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPW study) found that 'a significant number of personnel with mental disorders had received no care in the previous 12 months'.¹ The MHPW study found potential stigma to be a 'substantial issue', which limited the probability that ADF members would seek treatment for mental ill-health,² explaining that:

Research indicates that two main factors contribute to the low uptake of mental health care: the fear of stigma and perceived barriers to care. Stigma is a negative attitude resulting from the acceptance and internalisation of 'prejudice or negative stereotyping', while barriers to care are the organisational, procedural or administrative aspects of access to mental health care that may preclude or reduce access to mental health treatment and support. Barriers may include issues associated with confidentiality, anonymity and confidence in the mental health service providers. These are influenced to varying degrees by internalised stigmas about access to care and the consequences of asking for help.³

5.3 The MHPW study found that among its respondents, the highest rated barrier to personnel seeking help for a 'stress-related, emotional, mental health or family problem' in the ADF was the concern that seeking help would reduce their deployability (36.9 per cent). The highest perceived stigma that concerned members

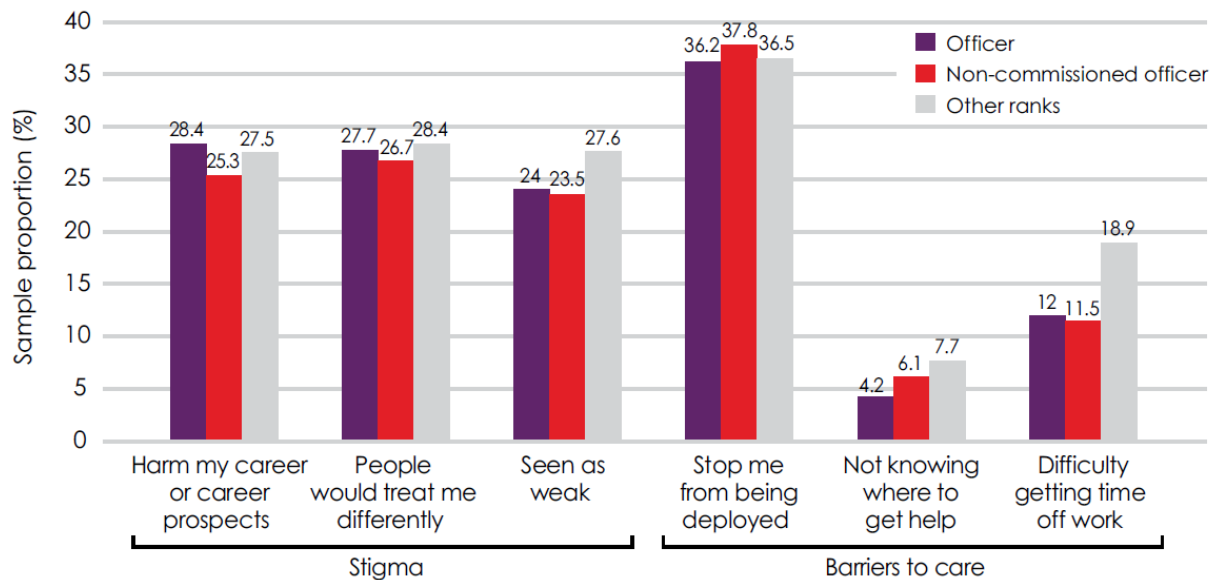
1 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 207.

2 Department of Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. 200.

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

was that people would treat them differently (27.6 per cent) and that seeking care would harm their careers (26.9 per cent). The findings are outlined in Figure 5.1.

Figure 5.1 – Estimated prevalence of stigma and barriers to care, by rank



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

5.4 A significant number of submissions also identified stigma surrounding mental ill-health and perceived barriers to care as key factors limiting the likelihood that ADF members would seek treatment for mental ill-health.⁴ A study investigating PTSD and stigma in the Australian Army, conducted by John Bale for the Army in 2014, reported on Australian soldiers' experiences of stigma due to mental ill-health. One soldier commented:

After my break down and subsequent hospitalisation words cannot express how lost I felt, the confusion and most of all the feeling of despair. My Chain of command had no idea how to engage me and my unit turned its back on me. Life was hard enough, but it was made harder that I had served 18 years and was not farewelled from my unit, mess, or Corps. It was not

4 For example: Stand Tall for PTSD, *Submission 7*, p. 3; Mr Mark Keynes, *Submission 10*, p. 1; Walking Wounded, *Submission 18*, p. 2; Returned and Services League of Australia, *Submission 19*, p. 17; Australian Psychological Society, *Submission 22*, pp 4, 8; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 3, Dr Kieran Tranter, *Submission 27*, pp 38–40; Soldier On, *Submission 29*, pp 4, 6; Phoenix Australia, *Submission 30*, pp 2, 4; Legacy Australia, *Submission 39*, p. 3; Alliance of Defence Service Organisations, *Submission 40*, pp 2, 6–7; beyondblue, *Submission 41*, p. 4–5; Name withheld, *Submission 44*, pp 2–3; Slater & Gordon, *Submission 51*, p. 8; Major Stuart McCarthy, *Submission 54*, p. 4; Name withheld, *Submission 56*, p. 1; Royal Australian Armoured Corps Corporation, *Submission 59*, pp 6–8; Young and Well Cooperative Research Centre, *Submission 62*, pp 3, 6.

until then that I realised that the stigma surrounding mental health and especially PTSD within the Army was widespread.⁵

5.5 Another example told of a soldier being accused of malingering and his concerns being dismissed when asking for mental health support and assistance from members of his chain of command:

When first asking for assistance for mental health support from within my immediate chain of command [sergeant and warrant officer class 2] I was met with an attitude that I was malingering and the immediate questioning of my integrity as a JNCO.

I pursued the matter outside my chain of command, although still within my unit, and a meeting with the unit RSM was arranged. I raised my concerns about my mental health and wellbeing and was told to 'harden the f**k up' and to get on with my job.⁶

5.6 The committee received similar evidence from ADF members and veterans who told the committee that if ADF members raise concerns regarding mental ill-health they are often dismissed or accused of malingering.⁷ Mr Matthew McKeever, a veteran, told the committee of his experiences, asserting that ADF members who are struggling with mental ill-health, or even physically injured, are commonly ostracised and called 'lingers':

As soon as they find out that you have a mental illness or any kind of illness, regardless of whether it is a knee, back or whatever, you are treated as a malingerer and you are treated quite badly. They do not want to acknowledge you; they want to kick you out as soon as possible.⁸

You want to ask for help, but you know what the reaction is going to be. I was a platoon sergeant. I used to sit in on med boards. I know exactly what goes on in them. The words that are thrown around are, 'He's weak. He is a linger. Let's just kick him out.' I have seen it firsthand because, as a platoon sergeant, I am part of that criteria. I would quite often be spoken down to because I would stand up for the soldier and say, 'No, that's not right. He's got a serious injury.'

I had a soldier who, at 21, had a hip replacement. They just booted him out of the army as a linger. That is not acceptable. They go on about mateship, courage and initiative. Yes, courage and initiative is what you have. Where does the mateship come into it? It does not.⁹

5 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 17.

6 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 17.

7 For example: Mr Douglas Steely, *Submission 6*, p. 16; Mr Mark Keynes, *Submission 10*, p. 3; Mr Jeremy Davey, *Submission 25*, p. 4; Dr Niall McLaren, *Submission 50*, p. 3; Slater & Gordon Lawyers, *Submission 51*, p. 9; Major Stuart McCarthy, *Supplementary Submission 54.1*, p. 2; Name withheld, *Submission 70*, p. 4.

8 Mr Matthew McKeever, *Committee Hansard*, 1 September 2015, p. 35.

9 Mr Matthew McKeever, *Committee Hansard*, 1 September 2015, p. 39.

5.7 Dr Niall McLaren pointed to ADF cultural views of strength as a significant contributing factor to the stigma surrounding mental ill-health:

Compounded in all of this is the intense stigma directed against people with mental problems in the Defence forces, and this stems from the myth of the 'real man'. The myth of the 'real man' is that there is no such thing as pain, sickness or mental disorder, only weakness of will. Anybody who shows pain, sickness or mental symptoms—and this is continuing with the myth—is weak and must be treated harshly until he gets tough 'like us'. That myth is absolutely rife. It is everywhere. It is in the air that people breathe in the Defence forces. Of course, it is fantasy.¹⁰

5.8 The Chief of the Defence Force (CDF), Air Chief Mark Binskin, acknowledged that stigma regarding mental ill-health is 'one of the biggest challenges we continue to face in the Australian Defence Force'.¹¹ However, when asked by the committee, the CDF disagreed with the allegations that Defence had a cultural problem regarding members seeking assistance when struggling with mental ill-health being ostracised and accused of malingering, responding that 'No, I think that we have had issues in the past and I am sure that there are pockets there now, still, that we will have to work on from a cultural point of view for people to understand that this is a command issue in looking to rehabilitate our people'.¹²

5.9 Defence assured the committee that it has introduced a range of educational resources and activities to reduce stigma surrounding mental ill-health:

...board developments and achievements since 2009 include...mental health education resources and activities such as the annual ADF Mental Health Day to reduce stigma and barriers to care by increasing awareness of mental health issues and understanding of PTSD, depression, suicide prevention and alcohol misuse and how to seek help as early as possible.¹³

5.10 In the ADF Mental Health & Wellbeing Plan 2012-2015 (MHWP), Strategic Objective 1 is 'to promote and support mental health fitness in the ADF' and aims for:

- a culture that promotes wellbeing and reduces the stigma and barriers to mental health care;
- ADF personnel who are mental health literate and know when, how, and where to seek care for themselves and their peers; and
- selection, training, and command systems that promote good mental health and wellbeing.¹⁴

10 Dr Niall McLaren, *Committee Hansard*, 1 September 2015, pp 33–34.

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

12 Air Chief Mark Binskin, Chief of the Defence Force, Department of Defence, *Committee Hansard*, 21 September 2015, pp 6–7.

13 Department of Defence, *Submission 34*, p. 4.

14 Department of Defence, *ADF Mental Health & Wellbeing Plan 2012-2015*, p. 12.

Impact of mental ill-health on deployment and career

5.11 The MHWP study found that among its respondents, the highest rated barrier to personnel seeking help for a 'stress-related, emotional, mental health or family problem' in the ADF was the concern that seeking help would reduce their deployability (36.9 per cent) and that seeking care would harm their careers (26.9 per cent). This was also reflected in the evidence received by the committee.¹⁵

5.12 Walking Wounded told the committee that the medical classification system, and in particular, the requirement that Army personnel be able and ready to deploy, reinforces and confirms ADF members' concerns that their deployability is inextricably linked to their employability:

Most soldiers are honest but most soldiers are realists too. Some years ago, when they changed the medical classification system in Army so that you could no longer serve if you had an injury that prevented you from serving overseas, that cut out a whole bunch of people who were very useful in Army. Just because they could not deploy did not mean they could not do good work elsewhere. I served many years ago with a major at Kapooka, and it was not until I saw him running in PT gear that I realised he only had one leg. He lost a leg in Vietnam thanks to a mine but he had served—and this was 20 years after the end of Vietnam—quite happily with a wooden leg. I thought: why not? Why would you want to lose that experience if that person can still provide that service? We are not going to send him overseas to fight again but, gee, there are lots of good jobs he could do in Army otherwise.

Probably the greatest problem now is that the medical classification system means that, if you are not ready to deploy, you cannot continue employment in the Army. For a lot of young men and women that means that they are losing the job they have always wanted. That is something that needs to be addressed. When you are in uniform, you need that understanding that the organisation is going to look after you, that it is going to keep you on board and you have got that reassurance. Certainly when I was a digger that was the case—you knew that you would certainly not be losing a job because you had suffered a bad injury that you might not get back from. That is not the case these days, of course.¹⁶

15 For example: Mr Mark Keynes, *Submission 10*, p. 1; Returned and Services League of Australia, *Submission 19*, pp 3, 7, 17; Mr Jeremy Davey, *Submission 25*, p. 3; Australian Families of the Military Research and Support Foundation, *Submission 26*, p. 16; Dr Kieran Tranter, *Submission 27*, pp 18, 38–39; Soldier On, *Submission 29*, p. 4; Phoenix Australia, *Submission 30*, p. 2; beyondblue, *Submission 41*, pp 4–5; Name withheld, *Submission 44*, p. 3; Slater & Gordon Lawyers, *Submission 51*, p. 8; Royal Australian Armoured Corps Corporation, *Submission 59*, p. 7; Mr Bradley Skinner, Executive Officer, Walking Wounded, *Committee Hansard*, 1 September 2015, p. 6.

16 Mr Bradley Skinner, Executive Officer, Walking Wounded, *Committee Hansard*, 1 September 2015, p. 6.

5.13 The Returned and Services League of Australia (RSL) stated that many ADF members fear the impact that disclosing mental ill-health will have on their ability to support their family:

Given a relative lack of civilian qualifications, many servicemen/women (with mortgages and young families) fear the impact that disclosing psychological injury will have on their ongoing employability, deployability, promotional opportunities and therefore their incomes.¹⁷

5.14 Mr Mark Keynes told the committee:

Probably the biggest problem is the stigma associated with seeking help. Many troops believe that anyone who asks for help is unlikely to deploy and will probably be medically discharged. Many believe that asking for help can be a career ending move, hence the stigma.¹⁸

5.15 Mr John Bale, in his report regarding PTSD and Stigma in the Australian Army, highlighted ADF members' fears of being discharged as a key factor in their reluctance to seek treatment for mental ill-health, especially for ADF members of lower rank:

Job security is vital to soldiers. Soldiering is key to the perceived self-worth of many who serve, and termination of employment by the Army is a dramatic and often confronting experience and one that soldiers will do almost anything to avoid. The fear of being discharged due to the disclosure of PTSD is currently a significant barrier to care, and a promise made by the senior leadership of the ADF and the Australian Army does little to reassure the lower ranks of the Army who are among those most affected by PTSD.¹⁹

5.16 To allay these fears, Mr Bale called for the ADF to highlight positive experiences from currently serving ADF members who have undergone rehabilitation for mental ill-health and have successfully returned to their career. Mr Bale also noted that this will also encourage ADF members to seek treatment early, to improve their chances of successful rehabilitation:

The most effective way to allay fears over job security for those who seek treatment for PTSD is to highlight positive experiences from currently serving soldiers who have been rehabilitated and subsequently enjoyed successful careers. These soldiers' stories, highlighting their successful return to an Army career, present a highly effective means of reassuring those with PTSD that they will only be medically discharged if they cannot be successfully rehabilitated. This message can also be useful in reinforcing the need for early intervention, signalling the fact that the sooner individual sufferers seek help, the greater the chance of their recovery, and the less likely they are to face discharge.²⁰

17 Returned and Services League of Australia, *Submission 19*, p. 17.

18 Mr Mark Keynes, *Submission 10*, p. 1.

19 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 32.

20 Mr John Bale, *PTSD and Stigma in the Australian Army*, October 2014, p. 32.

5.17 Defence emphasised its commitment to rehabilitation, informing 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. Defence provided three recent examples of ADF members of differing ranks that completed a rehabilitation program following referral for mental illness:

The first example involves an officer who was diagnosed with PTSD following an operational deployment in 2011. The officer's health care and rehabilitation program included a six week PTSD program. The officer was successfully returned to work in his current unit. As at October 2015, it is reported that the officer remains well supported by his unit and colleagues, and his ongoing prognosis and needs are being monitored by his health care team.

The second example involves a Senior Non Commissioned Officer (SNCO) who was medically downgraded because of both physical and mental health conditions related to multiple deployments. During 2014, the SNCO was provided with clinical treatment and health care, and referred to the ADF Rehabilitation Program. With the support of the rehabilitation consultant, commanding officer and health care team, the SNCO remained in the unit and was given the time to recover and achieve a full return to work outcome. The SNCO was medically upgraded in mid 2015, is undertaking a military course and will potentially be posted and deployed again in 2016.

The third example involves a junior ranked soldier with specialist skills who witnessed deaths during multiple deployments, resulting in a mental health condition. This member was provided with health care and referred for rehabilitation during 2013. The rehabilitation was successful, with the member being medically upgraded, promoted to a Non Commissioned Officer (NCO), and deployed on operation again in 2014.²¹

5.18 The RSL also commended the ADF, noting the 'great step forward' of providing a mandatory two-year period of treatment, rehabilitation and/or vocational training for ADF members allowing members to adapt their career plans:

The ADF's recent initiative of giving their employees a mandatory 2 year period of treatment/rehabilitation/vocational training (either back into ADF employment or in the civilian world) once a significant injury is identified is a great step forward.²²

5.19 Defence developed a 30-minute documentary, *Dents in the Soul—helping to cope with PTSD*, which is available from the Defence Health portal website. The documentary aims to 'de-stigmatise PTSD and to show that it can potentially happen to anyone'. It acknowledges ADF members' fears of stigma and condemns attitudes that mental ill-health is 'weakness'. The documentary calls for 'psychological sentry

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

22 Returned and Services League of Australia, *Submission 19*, p. 18.

duty' asserting that commanders and fellow ADF members have a duty to look out for and to help anyone struggling with mental ill-health and declaring that those who do not have failed their subordinates or their mates.²³ The documentary features interviews with current ADF members who have undergone successful rehabilitation for PTSD and returned to work, emphasising that 'recovery rates from PTSD are high but early diagnosis and treatment are particularly important'. It strongly and repeatedly emphasises that Defence has invested in and values ADF members and states its desire to rehabilitate and retain its members.²⁴

5.20 Aspen Medical reported that 42 per cent of its clinicians agreed or strongly agreed with the statement that there is increasing awareness and acceptance of mental health issues and PTSD amongst Defence personnel which is reducing the stigma formerly attached to mental health issues, with 21 per cent disagreeing or strongly disagreeing. Aspen Medical commented that 'this suggests that attitudes are changing within the ADF and that the efforts of the ADF and JHC have met with some success', as well as noting that 'it is also clear that this cultural shift will take more time to become fully embedded within the ADF'.²⁵

Department of Veterans' Affairs claims processes

5.21 DVA is responsible for a range of programs providing 'care, compensation, income support, and commemoration for the veteran and defence force communities and their families'. DVA administers three key pieces of legislation which governs veterans access to care and support entitlements:

- *Veterans Entitlements Act 1986* (VEA), which provides compensation, income support, and health services for those current and former members of the ADF who have rendered services in wars, conflicts, peacekeeping operations, and certain other deployments before 30 June 2004. Current and former ADF members with peacetime service between 1972 and 1994 and some veterans with warlike service and non-warlike service after 1 July 2004 may also have access to certain VEA entitlements;
- *Safety, Rehabilitation and Compensation Act 1988* (SRCA), which is workers' compensation legislation that applied to members and former members of the ADF, Reservists, Cadets, and Cadet Instructors and certain other persons who hold an honorary rank in the ADF, as well as members of certain philanthropic organisations that provide services to the ADF; and
- *Military Rehabilitation and Compensation Act 2004* (MRCA), which provides compensation and rehabilitation for current and former members of the ADF

23 Department of Defence, Post Traumatic Stress Syndrome, Dents in the Soul – helping to cope with PTSD, <http://www.defence.gov.au/Health/HealthPortal/PTSDDVD.asp>, accessed 11 February 2016.

24 Department of Defence, Post Traumatic Stress Syndrome, Dents in the Soul – helping to cope with PTSD, <http://www.defence.gov.au/Health/HealthPortal/PTSDDVD.asp>, accessed 11 February 2016.

25 Aspen Medical, *Submission 38*, p. 69.

as well as Cadets, Cadet Officers, and Instructors whose injury or disease is caused by service on or after 1 July 2004. The MRCA superseded the SRCA at this date for DVA, as well as most of the provisions contained within the VEA.²⁶

5.22 There are two ways that veterans can apply to DVA for assistance with mental health conditions:

- the non-liability pathway: for certain mental health conditions whatever the cause, to receive treatment only; and
- the liability pathway: for mental health conditions related to service in the ADF, to receive compensation and treatment.²⁷

Non-liability pathway

5.23 In 2013, DVA approved 1,244 non-liability applications for mental health and in 2014, approved 3,826.²⁸ DVA advised the committee that the eligibility requirements for non-liability mental health service provision were expanded in 2014 and again in 2015. Non-liability mental health services are now available to anyone who has deployed on operations overseas or has completed three or more years of continuous service in peacetime since 1972.²⁹

5.24 Under the new arrangements, DVA can pay for treatment for diagnosed PTSD, anxiety, depression, alcohol use disorder, or substance use disorder whatever the cause. Furthermore, DVA can now accept diagnosis from vocationally registered GPs, clinical psychologists, or psychiatrists. If a person has been diagnosed with one or more of these conditions, they are issued with a White Treatment Card (White Card), which provides access to treatment such as GP care; specialist care in the community, such as from a psychologist or psychiatrist; and hospital care.³⁰

5.25 A number of submissions supported non-liability mental health service provision and called for eligibility to be broadened further.³¹ The RSL described the provision of non-liability support as 'invaluable' but called for eligibility to be extended to everyone who has served in the ADF:

DVA's non-liability mental health support for eligible veterans has proved to be invaluable for the veterans who often present to an RSL Pension Officer at breaking point. This allows them to immediately access specialist

26 Department of Veterans' Affairs, *Submission 35*, p. 52.

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

28 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 2.

29 Department of Veterans' Affairs, *Submission 35*, p. 25.

30 Department of Veterans' Affairs, *Submission 35*, p. 25.

31 For example: Returned and Services League of Australia, *Submission 19*, p. 11; Mr Robert Shearman, *Submission 21*, p. 4; Slater & Gordon Lawyers, *Submission 51*, p. 13; and Dr Kevin Kraushaar, *Submission 64*, p.2.

health while their DVA claim is processed. The RSL would support the extension of non-liability mental health support to all who have served in the ADF.³²

Liability pathway

5.26 A serving or ex-serving ADF member who has a medical condition, including mental health conditions, for reasons related to their service, can make a liability claim. Once the liability claim has been accepted, DVA can provide services such as rehabilitation (including vocational assistance), medical treatment, (such as White or Gold Treatment Cards), attendant care, household services, and a range of other benefits. Compensation may also be provided for an inability or reduced ability to work or to recognise the effects of a permanent impairment resulting from a service-related incident.³³

5.27 DVA assesses claims to determine whether the injury, illness, or disease is related to the claimant's service, with most claims being assessed under the VEA, SRCA or MRCA, depending on which piece of legislation applies to the claimant. Claims processed under the VEA or MRCA are assessed using Statements of Principles, which list factors that 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death and which could be related to military service. The Statements of Principles are determined by the Repatriation Medical Authority, which consists of a panel of practitioners eminent in fields of medical science. Claims processed under the SRCA are assessed 'using available medical evidence to support consideration of a disease, injury, or illness'.³⁴

Impact of claims processes on mental health of claimants and their families

5.28 The committee received considerable evidence regarding the difficulties that many veterans, especially those struggling with mental ill-health, have when seeking assistance from DVA, and the detrimental impact that the claims process can have on their mental health.³⁵ The RSL told the committee that 'the DVA Compensation process complicates, aggravates and perpetuates the pre-existing psychological distress suffered by veterans and their families'.³⁶

32 Returned and Services League of Australia, *Submission 19*, p. 11.

33 Department of Veterans' Affairs, *Submission 35*, p. 24.

34 Department of Veterans' Affairs, *Submission 35*, p. 24.

35 For example: Returned and Services League of Australia (Wide Bay Burnett District), *Submission 3*, pp 1–5; Dr Jerome Gelb, *Submission 5*, pp 2–3; Mr Douglas Steley, *Submission 6*, pp 2–6; Mr Robert Shortridge, *Submission 16*, pp 5–6; Returned and Services League of Australia, *Submission 19*, p. 18; Dr Kieran Tranter, *Submission 27*, p. 52; Soldier On, *Submission 29*, p. 9; Partners of Veterans Association of Australia, *Submission 42*, pp 9–10; Name withheld, *Submission 44*, pp 3–6; Miss Alanna Power, *Submission 48*, pp 1–4; Slater & Gordon Lawyers, *Submission 51*, pp 8, 19–20; Mr John Skewes, *Submission 52*, pp 1–8; Mr John Lawler, *Submission 58*, pp 1–23; Mrs Catherine Lawler, *Submission 66*, pp 1–8; Name withheld, *Submission 67*, pp 1–3; Mr Dennis Bass, *Submission 69*; KCI Lawyers, *Submission 71*, pp 1–16; Name withheld, *Submission 79*, pp 1–2.

36 Returned and Services League of Australia, *Submission 19*, p. 18.

5.29 Slater & Gordon Lawyers described the DVA claims process as 'combative' noting that its clients' experiences with the DVA claims process are detrimental to their already compromised mental health:

We are witnessing Veterans being drawn into a system of combative legislation with a bureaucracy of Departments shifting responsibility. My team can attest to the voices of other Veterans advocates and ex-service organisations that lodging claims with the DVA for compensation and treatment of physical and mental issues is "like going through a meat grinder, it grinds you up".³⁷

5.30 Soldier On highlighted the confusing and overwhelming nature of the DVA claims processes, noting that it 'routinely aggravates existing mental health conditions':

The process of navigating a claims process routinely aggravates existing mental health concerns in many people attempting to access support from DVA. One partner of a veteran said they weren't in a position to sit down and manage their way through the confusing mix of support available. She described it as looking at the night sky. "There are many bright, shiny places to go, but out of the hundreds of options, where are we meant to go? What we need is a map, we don't need more stars."³⁸

5.31 Mrs Catherine Lawler, the wife of a veteran struggling with mental ill-health, told the committee that the claims process can be overwhelming for both veterans and their families. Mrs Lawler noted that the 'torturous and arduous' claims process results in many veterans giving up on their claim:

...lodging a claim with DVA may seem to be a reasonable straight forward process, but the legal aspects under consideration are complex, potentially involving multiple pieces of legislation, the administrative requirements exacting, and the time frames very lengthy. And the veteran is expected to deal with all of this while living with the debilitating effects of PTSD or mental illness.

It is a torturous and arduous process that serves only to increase the stress levels of the veteran and it impacts negatively on them and their family. The distress generated frequently becomes too much for the veteran, and they give up on their claim, walk away from their family, or take their own lives. There is no support within this process for the partners or families of veterans with PTSD or mental illness.³⁹

Criticisms of DVA's delivery models and claims processes

5.32 In 2013, the Australian Public Service Commission conducted a capability review of DVA. The review found that 'DVA staff are committed to supporting the Australian veteran community' but that 'a major transformational leap forward is

37 Slater & Gordon Lawyers, *Submission 51*, p. 22.

38 Soldier On, *Submission 29*, p. 9.

39 Mrs Catherine Lawler, *Submission 66*, p. 2.

required'.⁴⁰ The capability review expressed serious concerns regarding DVA's delivery models and compensation claims processing:

DVA's current operating structure is a complex matrix—an unsustainable hybrid of fragmented national and dispersed business lines, comprising multiple service models, much of which is delivered and processed in-house (with the exception of health services which is outsourced).

This complexity has partially been shaped by the combination of multi-act eligibility and an increase in claims made under the MRCA which is more challenging to administer, but primarily through the division of responsibility for staff, policy and service delivery, all of which can be split across two or three divisions and two or more locations. This complex structure lacks scale and has contributed to the development of fiefdoms in state locations and functional silos to the detriment of consistency and efficiency of performance across key business outcomes, particularly compensation claims processing.⁴¹

5.33 Mr Brian Briggs, Practice Group Leader, Military Compensation, at Slater & Gordon Lawyers described the DVA claims processes as 'chaotic' identifying 'fundamental problems' with its culture, leadership and equipment:

My first suggestion is this simple proposition: tackle the chaotic claims handling by DVA. An Australian Public Service Commission review found that the Department of Veterans' Affairs has fundamental problems with its culture, leadership and equipment. The department has itself admitted that it cannot deal with the complicated needs of many physically and mentally injured veterans. The APSC review further found that the decision-making process at Veterans' Affairs was a confusing mess of committees with duplicated membership and overlapping agendas. For example, 200 individual ICT systems operating within a single department cannot be efficient or productive. The structure of small cells of public servants working in isolation and not considering the whole picture has failed. Files are shipped all over the country—one section may deal with liability before another considers incapacity and then another rehabilitation or treatment. Permanent impairment and compensation will be looked at by an entirely separate team. This entire bureaucratic file shuffling and passing on of an injured member's claim causes significant delays. The frustration of my clients at this inefficiency and ineptitude often overwhelms.⁴²

5.34 DVA emphasised its desire to improve its engagement with clients, advising the committee that in late 2014, it commissioned an independent survey to help improve client services which collected approximately 3,000 responses. The results

40 Australian Public Service Commission, *Capability review: Department of Veterans' Affairs*, November 2013, pp 5–6.

41 Australian Public Service Commission, *Capability review: Department of Veterans' Affairs*, November 2013, p. 38.

42 Mr Brian Briggs, Practice Group Leader, Military Compensation, Slater & Gordon Lawyers, *Committee Hansard*, 1 September 2016, p. 15.

showed that 89 per cent of clients were satisfied with DVA's client service and 90 per cent of clients 'believed that the Department is honest and ethical in its dealings and is committed to providing high quality client service'.⁴³

5.35 Mr Shane Carmody, the Chief Operating Officer of DVA, acknowledged both the findings of the Capability Review and the comments made by Mr Briggs, assuring the committee that DVA has strategies in place to address DVA's operating structure; governance arrangements; information and communications technology; approach to clients; culture and staffing; and its efforts to formulate effective strategy, establish priorities, and use feedback:

The review team identified three key areas of focus, and we have discussed those I think more than once during the estimates process. They saw that we needed urgent attention to transforming our operating structure; our governance arrangements and information and communications technology; our approach to clients, culture and staffing; and our efforts to formulate effective strategy, establish priorities and use feedback. All of these issues have been identified, and strategies are in place to deal with them through DVA's strategic plan towards 2020.

In terms of operating structure, as we mentioned during a number of hearings, part of the creation of my position as chief operating officer was to streamline the governance process and take control of a number of key aspects of business. We have programs underway in terms of our clients, culture and staffing, including a strong program such as 'It's why we're here', a very clear program to ensure that our staff have a very good understanding of the client base we are dealing with and the injuries and illnesses they face.⁴⁴

Complex application processes

5.36 A number of submissions highlighted the complex and confusing applications processes required to lodge a claim.⁴⁵ The RSL acknowledged that DVA's 'strict processes are required to efficiently and fairly investigate large number of claims' and that DVA has 'a defined budget' within which it must operate but noted that this has

43 Department of Veterans' Affairs, *Submission 35*, pp 6–7.

44 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 4.

45 For example: Returned and Services League of Australia (Wide Bay Burnett District), *Submission 3*, pp 1–5; Dr Jerome Gelb, *Submission 5*, pp 2–3; Mr Douglas Steley, *Submission 6*, pp 2–6; Mr Robert Shortridge, *Submission 16*, pp 5–6; Returned and Services League of Australia, *Submission 19*, p. 18; Soldier On, *Submission 29*, p. 9; Partners of Veterans Association of Australia, *Submission 42*, pp 9–10; Name withheld, *Submission 44*, pp 3–6; Miss Alanna Power, *Submission 48*, pp 1–4; Slater & Gordon Lawyers, *Submission 51*, pp 8, 19–20; Mr John Skewes, *Submission 52*, pp 1–8; Mr John Lawler, *Submission 58*, pp 1–23; Mrs Catherine Lawler, *Submission 66*, pp 1–8; Name withheld, *Submission 67*, pp 1–3; Mr Dennis Bass, *Submission 69*; KCI Lawyers, *Submission 71*, pp 1–16; Name withheld, *Submission 79*, pp 1–2.

led to an adversarial system where DVA's focus appears to have shifted from supporting veterans to 'looking for reasons not to provide compensation':

...many veterans feel that they are viewed by DVA as trying to cheat the system until proven otherwise. The majority of veterans and advocates (with whom the RSL and other advocates have contact) relate that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the Administrative Appeals Tribunal, which indicates that the DVA is looking for reasons not to provide compensation rather than ways to support their clients.⁴⁶

5.37 Mr William Kearney, from the Wide Bay Burnett District of the RSL, told the committee that most veterans, and even many volunteer advocates, do not understand the complex legalities of the claims process and highlighted the significant consequences for veterans and dependants if they, or the volunteer advocates assisting them, are unable to correctly navigate the system:

The danger here is that well meant but incorrect advice, once put on a form, signed by the applicant, then submitted to the Department is evidence that **cannot** be undone. Further clarification may have a slim chance of repairing damage but this is extremely rare. The outcome of this is that a Veteran, at best, is locked into a lengthy appeals process, or alternately denied benefits for life that they could have been receiving if the case was done correctly.⁴⁷

5.38 DVA advised the committee that it has 'invested significantly' in its online capacity and improving clients' experiences with the claims processes. Clients can access online claiming for a range of DVA claims and applications, including claims for 'liability compensation following the death of a veteran, determining qualifying service, and service pension and income support supplement'. Furthermore, DVA advised that it has introduced an online 'single claim process' which negates the need for clients to make separate claims under different pieces of legislation:

The online claiming process is a single claim process rather than the client needing to make separate claims under different pieces of legislation. Claims will be considered under all relevant legislation to ensure clients have access to the full range of benefits for which they are eligible. The feedback received from ex-service representatives and departmental staff following a trial clearly showed that a single claim form is far less complex for clients.⁴⁸

5.39 The DVA website now also offers a range of services including 'Entitlement Self-Assessment', which comprises a series of questions to help existing and prospective DVA clients to assess their potential entitlements. This may be completed by a member or former member of the ADF, (including reservists and cadets) or dependants (partner/spouse or children). Clients can also access 'my Account', which

46 Returned and Services League of Australia, *Submission 19*, p. 18.

47 Mr William Kearney, Wide Bay Burnett District of the Returned and Services League of Australia, *Submission 3*, p. 3.

48 Department of Veterans' Affairs, *Submission 35*, p. 27.

allows clients to access a range of DVA services online. Clients can update contact details, access information about accepted medical conditions, make transport bookings, claim travel expenses, and access forms and fact sheets.⁴⁹

Recordkeeping, communications technology, and procedural errors

5.40 The committee received evidence regarding lost documents, long delays whilst waiting for documents to be physically transferred between offices, and procedural errors.⁵⁰ Soldier On told the committee that veterans have told them of documents being lost by DVA:

When we have spoken to a number of veterans it seems that sometimes their records are either lost or they are not handed over correctly. When you have a mental health injury, actually talking through the same thing again and again can be quite confronting, especially when you have to relive your wound. So, for whatever reason it seems that records are not passed on correctly. That may mean they are kept correctly but not passed on correctly.⁵¹

5.41 One submitter told the committee that confidential medical documents were lost by DVA on multiple occasions and outlined a number of procedural and clerical errors that were made by DVA over the two years it took for their husband's claim to be finalised:

Documents including confidential medical documents were lost on more than one occasion, and requests for responses to emails, phone calls and letters were consistently ignored. Months would pass without any updates to the claim, despite repeated requests for information.

A number of procedural mistakes and errors of judgement occurred during the course of the claim including:

- the date of onset of the illness being determined incorrectly (there was a 7 year difference)
- not receiving the White Card for treatment costs until after liability was established
- not being assessed for rehabilitation services despite requests for these services

49 Department of Veterans' Affairs, *Submission 35*, p. 27.

50 For example: Mr Douglas Steley, *Submission 6*, p. 39; Mr Robert Shortridge, *Submission 16*, pp 2, 6–7; Australia Psychological Society, *Submission 22*, p. 13; Australian Families of the Military Research and Support Foundation, *Submission 26*, pp 15, 35; Soldier On, *Submission 29*, p. 6; Partners of Veterans Association of Australia, *Submission 42*, pp 9–10; Name withheld, *Submission 44*, pp 4–5; Slater & Gordon Lawyers, *Submission 51*, p. 8; Mr John Skewes, *Submission 52*, pp 5–6; Mr John Bale, Chief Executive Officer and Co-Founder, Soldier On, *Committee Hansard*, 31 August 2015, p. 20.

51 Mr John Bale, Chief Executive Officer and Co-Founder, Soldier On, *Committee Hansard*, 31 August 2015, p. 20.

- the level of permanent impairment points determined by DVA was overturned on appeal by the Veterans Review Board (VRB)
- the procedures for determining the payment period for Incapacity Payments were found to be incorrect and also overturned on appeal by the VRB.⁵²

ICT systems

5.42 The capability review identified the state of DVA's ICT systems as a significant issue to be addressed, describing the systems as 'antiquated':

...the department is delivering through some 200 ICT systems which are so antiquated that new staff feel they have been transported back '10 years or more'. Applications are not integrated, making it difficult to obtain a whole-of-client perspective. This is further affected by a lack of a single client identification either within DVA or flowing from Defence through to DVA. Past investment has been a patchwork in the absence of a definitive ICT blueprint, which has generated cynicism and frustration.⁵³

5.43 Mr Carmody agreed that DVA has 'antiquated' ICT systems, assuring the committee that DVA was working to modernise and digitise its systems 'within the funding' available:

We do have challenges—I will admit those—without a doubt. I mentioned some during a hearing last week. We have antiquated ICT systems. We are doing our best to modernise those systems within the funding that we have available. We are doing our best to digitise our systems to move files off paper and on to digital systems. It will take time.⁵⁴

Case coordination

5.44 A number of submissions highlighted the lack of continuity when dealing with DVA and called for veterans making claims regarding mental ill-health to be assigned a case officer or staff member to act as a single point of contact.⁵⁵ One submitter called for DVA to assign a case officer to act as a single point of contact for claims relating to mental ill-health:

Each time we contacted DVA we would speak with a different staff member, who inevitably passed us on to someone else, usually in another

52 Name withheld, *Submission 44*, pp 4–5.

53 Australian Public Service Commission, *Capability review: Department of Veterans' Affairs*, November 2013, p. 39.

54 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 4.

55 For example: Mr Douglas Steley, *Submission 6*, p. 24; Returned and Services League of Australia, *Submission 19*, p. 33; Name withheld, *Submission 44*, p. 5; Mr John Lawler, *Submission 58*, pp 14–17; Mrs Catherine Lawler, *Submission 66*, pp 5–8; KCI Lawyers, *Submission 71*, p. 8.

state. A dedicated case manager, with specialist training in mental health awareness should be allocated to each case that involves mental illness.⁵⁶

5.45 DVA advised the committee that a small proportion of DVA clients are categorised as 'vulnerable with complex needs'. This might be because the client has serious wounds, illnesses, or injuries as a result of their service; a severe mental health condition; relationship or interpersonal difficulties; complex psychosocial needs; or a mix or some of all of these factors. DVA noted that, in general, case management refers to support provided to clients for:

- access to DVA systems and supports, usually referred to as 'case coordination', which are provided through DVA's case coordination service; and
- access to health care and community service, usually referred to as 'clinical care coordination', which are provided through DVA's health care card arrangements (for instance, through social workers) and also through the Veterans and Veterans Families Counselling Service (VVCS).⁵⁷

5.46 DVA informed the committee that in the 2015-16 budget, the government funded 'a new measure', worth approximately \$10 million over the forward estimates, to improve DVA's case coordination:

The measure will improve DVA's capacity to provide one-on-one tailored packages of support to veterans with complex needs, including mental health conditions. It will also improve the level of support and early intervention assistance provided to an increasing number of veterans with complex needs, particularly those returning from recent conflicts.⁵⁸

5.47 Furthermore, as of 8 February 2016, DVA has implemented a single, nationally consistent, model for supporting complex and multiple needs clients. DVA advised that the new model focuses on supporting clients with mental health conditions and/or complex needs and aims to provide a single point of contact:

In line with the aim of the Budget initiative, there is a focus on supporting clients with mental health conditions and/or complex needs. Staff working within the new model will provide a single point of contact where appropriate, help clients navigate DVA's processes to ensure they are accessing all of their entitlements, and connect clients with other community-based services and support where relevant.⁵⁹

5.48 DVA also provided data regarding client update of the various case management support options (see table 5.1).

56 Name withheld, *Submission 44*, p. 5.

57 Department of Veterans' Affairs, *Supplementary Submission 35.1*, p. 1.

58 Department of Veterans' Affairs, *Submission 35*, p. 8.

59 Department of Veterans' Affairs, *Supplementary Submission 35.1*, p. 1.

Table 5.1–Client update of case management support

Program/Support	Data on client uptake or population*
<p><i>DVA's case coordination service</i></p> <p>This is a single service providing those clients requiring additional support with a primary or single point of contact for the whole of the Department.</p>	<p>From January 2010 to June 2015, over 1,100 clients were referred to the Case Coordination Program.</p> <p>As part of the information exchange strategy between Defence and DVA, in 2014-2015 Defence issued DVA with:</p> <p>17 NOTICAS* priority notifications; and 961 medical separation notifications.</p> <p>*Where a member is medically classified as seriously or very seriously wounded, injured, or ill (defined as an injury or illness that endangers the person's life; significantly disables the person; or materially affects the person's future life).</p>
<p><i>Social work services under DVA's allied health arrangements</i></p> <p>Social workers help clients overcome a range of problems in relation to stressful life events such as death or divorce and assist them to deal with family, health, employment, income support or accommodation related issues. The services provided by eligible social workers may include:</p> <ul style="list-style-type: none"> • general counselling and case management; and • health service co-ordination and facilitating access to community services. 	<p>In 2014-15, there were 906 clients who received support under DVA's social work allied health items, for treatment or case coordination.</p>
<p><i>Veterans and Veterans Families Counselling Service (VVCS)</i></p> <p>VVCS provides free and confidential, nation-wide counselling and support for war and service-related mental health conditions, such as posttraumatic stress</p>	<p>In 2014-15, there were 227 clients who had their cases managed by VVCS. This compares with 126 complex care cases managed in 2013-14.</p>

disorder (PTSD), anxiety, depression, sleep disturbance and anger.	
VVCS supports a number of clients in complex situations with comorbidities and or who find it difficult to engage and manage the range of health and social care services they require.	

* Note: the same client may access more than one type of support.

Department of Veterans' Affairs, *Supplementary Submission 35.1*, pp 2–3.

Timeframes

5.49 A number of submissions raised concerns regarding the time taken to process claims.⁶⁰ Slater & Gordon Lawyers and KCI Lawyers called for the introduction of time limits for the processing of claims. Slater & Gordon Lawyers noted that state and territory bodies as well as international bodies have statutory timeframes in which decisions are made regarding the processing of claims for assistance and compensation:

...most important, is that time frames are now put in place to ensure that claims for help and other things are dealt with. Every state and territory system in Australia has time frames for decision making. Defence personnel in the UK and US are protected by time frames for decision making. But in Australia there are none, so injured personnel can literally be left waiting for years...An increase of \$10 million announced in the latest budget to increase the numbers of delegates who make decisions is welcome but will not adequately solve the problem unless time frames are mandated. I strongly urge the committee to consider the issue of deeming time periods, which will have a significant benefit in assisting not only the PDSO sufferers but also all of our injured military personnel.⁶¹

5.50 KCI Lawyers commented that the long processing times unfairly deny veterans and their families access to much needed assistance:

DVA continue to cause Veterans and their families substantial delays as they have no time limits imposed to make timely decisions. This remains a vexed issue when compared to other Workers' compensation...The time has well and truly come for DVA to make a decision within a reasonable and a defined period. The old adage of "*justice delayed is justice denied*" is also

60 For example: Dr Jerome Gelb, *Submission 5*, pp 2–3; Mr Douglas Steley, *Submission 6*, pp 12–13; Mr Robert Shortridge, *Submission 16*, pp 5–6; Returned and Services League of Australia, *Submission 19*, p. 38; Mr Robert Shearman, *Submission 21*, p. 5; Mr Geoff Bolwell, *Submission 33*, pp 23–24; Partners of Veterans Association of Australia, *Submission 42*, pp 9–10; Name withheld, *Submission 44*, pp 3–6; Miss Alanna Power, *Submission 48*, pp 1–4; Slater & Gordon Lawyers, *Submission 51*, pp 13–19; Mr John Lawler, *Submission 58*, pp 1–23; Mrs Catherine Lawler, *Submission 66*, pp 1–8; KCI Lawyers, *Submission 71*, pp 1–16.

61 Mr Brian Briggs, Practice Group Leader, Military Compensation, Slater & Gordon Lawyers, *Committee Hansard*, 1 September 2015, p. 16.

true when considering the delay to provide compensation payments by making timely and accurate decisions is akin to denying the benefit.⁶²

5.51 DVA assured the committee that 'the Government is very focussed on improvements to reduce the time taken to process compensation claims' describing it as a 'key early intervention initiative'.⁶³ The average times taken to process compensation claims under the VEA and liability claims under MRCA and SRCA for the financial years 2011-12 to 2013-14 are listed in table 5.2.

Table 5.2 – Time taken to process claims

	TARGET AVERAGE days	2011-12 OUTCOME days	2012-13 OUTCOME days	2013-14 OUTCOME days	2013-14 CHANGE days
VEA	75	74	79	75	-4
MRCA	120	158	155	144	-11
SRCA	120	180	171	160	-11

Department of Veterans' Affairs, *Submission 35*, p. 28.

5.52 DVA disagreed with calls to introduce statutory timeframes. Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support, advised the committee that statutory timeframes have been considered in the past and were found to be unsuitable for DVA's unique situation:

Last year, we tabled a report in the Senate on the review of statutory time frames which looked at the options that we might be able to adopt in relation to our claims processes, but overall there are two significant issues in relation to compensation claims that we receive compared to compensation claims under states' compensation and private compensation schemes. Firstly, we have no time limit on when a member—a veteran—can lodge a claim. So an injury could have occurred in the forties, the fifties or the sixties, and a veteran is still able to lodge a claim with us; there is no limit. We do not have any directions on the state of the claim that we receive. Essentially, a veteran can put a claim in which just has their name, address and injury, and they sign it. A lot of other compensation schemes actually will not accept a claim until it is fully completed. In our case, that would mean that it has not only the details of the veteran but also reports from their medical specialists or doctors about the nature of the injury and the illness, proof of identity that the veteran has served, and details of where they served and when they served. We do not do that; we allow veterans to come in and immediately give us their claims. We then go away and try and get that additional information. We will contact their specialists and ask them to produce a report. We will contact Defence and ask them to

62 KCI Lawyers, *Submission 71*, p. 16.

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

produce details of their medical records and the incident that gave rise to the compensation. I think, overall, we are in a very different position to other compensation schemes in Australia.⁶⁴

5.53 Mr Carmody also expressed concerns regarding the introduction of statutory timeframes, noting that it could damage the integrity of the claims system:

...one of the key points in statutory time frames is what you wish to achieve. For example, do you want to have a deemed acceptance at the end of a particular period? If that were the case, that would encourage everybody to go slow on their claims process, because we have to collect all of the information. If you were to have a deemed acceptance, people would be reluctant to put in their material, because at the end of a particular period of time we are going to accept it anyway. That would be unfair across the whole system. If you decided to have a deemed rejection at the end of a particular period, if somebody gets 95 per cent through their claims process and the time elapses, they have to go back and start again. So there are some real issues in trying to manage this. A great amount of our time that is taken to process is taken up with collecting information which in other jurisdictions would be provided in advance. That is probably the simplest answer.⁶⁵

Availability of services in regional and remote areas

5.54 Some submissions highlighted a lack of available services, especially in regional or remote areas, as a significant barrier to treatment.⁶⁶ Ms Maria Brett, Chief Executive Officer of Psychotherapy and Counselling Federation of Australia, told the committee that due to workforce shortages, veterans seeking treatment may have to wait a 'significant amount of time':

...particularly relates to rural and regional areas, because we know there are workforce shortages. If you are trying to access one of the outreach counsellors from VVCS and you live in a place where someone is not available, you will actually be waiting, and that sometimes can be for quite a significant amount of time to get a service. This is why, in our discussions with the health minister we are very interested in potentially using

64 Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, pp 12–13.

65 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 13.

66 For example: 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.

counsellors to participate in a rural and regional trial, and that could be something potentially that DVA—⁶⁷

5.55 Ms Catherine O'Toole, Chief Executive Officer at Supported Options in Lifestyle & Access Services (SOLAS), advised the committee that 'specialist mental health services are very light on the ground in regional areas'. Ms O'Toole advised that SOLAS was working to build capacity in northern and western Queensland:

Specialist mental health services are very light on the ground in regional areas. Our organisation made a commitment, when we got federal funding some time ago, that we would work to build the capacity in our regional areas. That is why we subcontract in Charters Towers, Ingham, Ayr, Burdekin, Richmond and Hughenden—because there were no specialist mental health services. We have been able to build that capacity in that community. It is much more financially viable as well. We have also created jobs and built skill bases in those communities.⁶⁸

5.56 DVA acknowledged that, as it operates and purchases services from within the broader mental health system, workforce shortages can impact on the availability of services for veterans in regional and remote areas:

DVA operates within a broader mental health system and it is important to recognise that while there has been significant expansion of mental health services over the past two decades in Australia, this sector continues to have workforce shortages in the face of growing demand especially in some regional areas.⁶⁹

Committee view

Stigma and perceived barriers to care

5.57 Early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. As such, the committee is very concerned that perceived stigma surrounding mental ill-health continues to be identified as a significant barrier to ADF members and veterans seeking treatment for mental ill-health.

5.58 Evidence of ADF members who were brave enough to report mental ill-health and seek treatment being ostracised, ridiculed, and accused of 'malingering' is deeply disturbing and completely unacceptable. The committee acknowledges that Defence has introduced a range of educational resources and activities to reduce stigma surrounding mental health; however, it is clear that more must be done to root out and denounce stigma regarding mental ill-health.

67 Ms Maria Brett, Chief Executive Officer, Psychotherapy and Counselling Federation of Australia, *Committee Hansard*, 31 August 2015, p. 53.

68 Ms Catherine O'Toole, Chief Executive Officer, Supported Options in Lifestyle & Access Services (SOLAS), *Committee Hansard*, 1 September 2015, p. 51.

69 Department of Veterans' Affairs, *Submission 35*, p. 8.

Impact of mental health on career prospects

5.59 The MHWP study found that the highest rated barrier to ADF personnel seeking help was the concern that seeking help would reduce their deployability (36.9 per cent). The committee acknowledges that is a legitimate fear and a difficult one for Defence to address. Defence has an obligation to ensure that ADF member's duties do not detrimentally affect their health, that ADF members can undertake their duties without compromising the safety of themselves or others, and that the ADF as a whole maintains its operational capability.

5.60 The committee understands the principle that it would be inappropriate and irresponsible for Defence to deploy ADF members who are not mentally well enough for deployment, in the same way as it would be inappropriate for an ADF member who is not physically well enough to be deployed. However, this does not absolve Defence of its responsibility to address these fears. Defence should continue to emphasise the benefit of early identification and treatment of mental ill-health for an ADF members' long-term career prospects when considering seeking assistance for mental ill-health. Defence should also encourage ADF members to plan beyond their next deployment by showing examples of members who have successfully deployed after rehabilitation for mental ill-health.

5.61 An ADF member who chooses not to disclose or treat mental ill-health, and is subsequently deployed, is exposing themselves to significant risk of further deterioration of their mental health. This may result in a much more serious mental health condition which may ultimately lead to the ADF member being medically downgraded, medically discharged, or even the inability to work at all. Comparatively, an ADF member who disclosed and sought treatment for mental ill-health early may have their deployment delayed, but is significantly more likely to have positive mental health outcomes. This may result in later deployments, after mental health concerns have been addressed, and ultimately result in a longer and more successful career in the ADF.

Recommendation 11

5.62 The committee recommends that Defence mental health awareness programs do more to emphasise the benefit of early identification and treatment of mental ill-health for an ADF members' long-term career and encourage ADF members to plan beyond their next deployment.

Recommendation 12

5.63 The committee recommends that the Department of Defence and the Department of Veterans' Affairs develop a program to engage current and former ADF members, who have successfully deployed after rehabilitation for mental ill-health, to be 'mental health champions' to assist in the de-stigmatisation of mental ill-health.

DVA delivery models, claims processes, and ICT systems

5.64 Veterans and their families who are seeking assistance and treatment for mental ill-health must engage with DVA to receive it. Therefore, the extent to which DVA processes act as a barrier to the early identification and treatment of mental ill-

health is directly proportionate to the ease and speed with which veterans' claims are processed. As such, the committee is deeply concerned by evidence that the DVA claims process can be detrimental to the mental health of veterans seeking assistance and treatment for mental ill-health.

5.65 The Australian Public Service Commission's capability review highlighted considerable failings regarding DVA's operating structure; governance arrangements; information and communications technology; approach to clients; culture and staffing; and its ability to formulate effective strategy, establish priorities and use feedback. The committee acknowledges that DVA has strategies in place to address these shortcomings; however, it is clear that more must be done to ensure that veterans are able to quickly access the assistance and treatment they require.

5.66 The committee commends DVA for its efforts to simplify its complex claims process. The introduction of an online 'single claims process', which negates the need for clients to make separate claims under different pieces of legislation and ensuring that clients have access to the full range of benefits that they are eligible for, is a significant step towards improving client engagement. The committee also notes DVA's introduction of online 'entitlement self-assessment' and 'my Account' services.

5.67 The committee is very concerned by the evidence it received regarding lost documents, long delays whilst waiting for documents to be physically transferred between offices across different states and territories, and procedural errors. DVA's 'antiquated' ICT systems appear to be at the root of many of these concerns. The committee is not satisfied by DVA's comments that 'it will take time' to modernise these systems within the funding that it has available. The digitisation of records and modernisation of ICT systems must be made a priority and should be funded accordingly.

Recommendation 13

5.68 The committee recommends that the Department of Veterans' Affairs be adequately funded to achieve a full digitisation of its records and modernisation of its ICT systems by 2020, including the introduction of a single coherent system to process and manage claims.

5.69 Good case coordination is essential to ensuring that veterans and their families who are seeking assistance for mental ill-health can navigate the claims process with the minimum impact on their mental health. The committee is satisfied that DVA recognises this and is encouraged by the government's recent investment to improve DVA's case coordination. The committee is also pleased to note DVA's recent implementation of a single, nationally consistent, model for supporting complex and multiple needs clients, which will aim to provide a single point of contact during the claims process.

5.70 Early identification and treatment of mental ill-health is essential for achieving the best outcomes for ADF members and veterans with mental ill-health. As such, it is essential that claims are processed in a timely fashion, to ensure that veterans and their families are able to receive assistance and treatment as soon as

possible. The committee commends DVA for its non-liability mental healthcare provision and its recent expansions to the eligibility requirements to receive it.

5.71 The committee acknowledges DVA's assurances that it is aware of the importance of improving the timeliness of claims processing. The committee is satisfied that the strategies DVA is implementing to improve the timeliness of its claims processing, together with the digitisation of records and modernisation of ICT systems, will ensure that claims are processed within acceptable timeframes.

5.72 The committee acknowledges calls to introduce statutory timeframes; however, based on the evidence received, the committee is not convinced that mandating a timeframe will benefit veterans and may have unintended consequences.

Chapter 6

Discharge, transition to civilian life, and veteran homelessness

Introduction

6.1 This chapter considers the effectiveness of training, education, and transition support services provided to Australian Defence Force (ADF) members at discharge; the Memorandum of Understanding (MoU) between the ADF and Department of Veterans' Affairs (DVA) and the effective transfer of responsibility of care; and veterans experiencing homelessness due to mental ill-health and other issues related to their service.

Discharge

6.2 A number of submissions highlighted discharge as a critical time for ADF members, with poor transition experiences linked to poor reintegration and poor mental health outcomes.¹ Phoenix Australia noted that 'the process of transition is a critical point in the military/veteran lifecycle and one which, if not managed well, may be the beginning of a downward spiral'.²

6.3 Defence assured the committee that it provides comprehensive health support for ADF members at discharge, with all members undergoing a comprehensive Separation Health Examination prior to separation:

All ADF personnel undergo a comprehensive Separation Health Examination prior to separation which identifies all physical and mental health issues and ongoing treatment requirements, links them to civilian providers if applicable, completes paperwork for ComSuper (for medical discharges), assists with DVA compensation claim submissions and provides them with a medical summary and supporting documentation to take to their new civilian health care provider.³

6.4 Defence advised that the Separation Health Examination 'aligns closely with the DVA assessment to facilitate a smooth transition to the civilian health care sector for ADF personnel' as well as providing baseline health information for civilian health care providers.⁴ DVA advised the committee that the *Support for Wounded, Injured or*

1 For example: Veterans Care Association, *Submission 4*, p. 1; Mr Mark Keynes, *Submission 10*, pp 3–4; Mr Robert Shortridge, *Submission 16*, p. 4; Walking Wounded, *Submission 18*, p. 5; Returned and Services League of Australia, *Submission 19*, pp 6, 13, 16, 18, 23; Australian Psychological Society, *Submission 22*, pp 3–4, 12; Soldier On, *Submission 29*, p. 11; Phoenix Australia, *Submission 30*, pp 9–10; beyondblue, *Submission 41*, p. 5; Slater & Gordon Lawyers, *Submission 51*, p. 20; Young and Well Cooperative Research Centre, *Submission 62*, pp 1–2; Australian Peacekeeper and Peacemaker Veterans' Association, *Submission 78*, pp 3, 9–10.

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

3 Department of Defence, *Submission 34*, p. 18.

4 Department of Defence, *Submission 34*, p. 18.

Ill Programme provides support for personnel from the point of injury through to ongoing support after military service. It is a joint Defence and DVA undertaking to provide coordinated, transparent, and seamless support to individuals during their service and after transition from the ADF by:

- enhancing support for personnel with complex or serious medical conditions who are transitioning to civilian life;
- improving information sharing between Defence and DVA relating to injury or illness;
- simplifying processes involved in applying for an acceptance of liability for compensation; and
- streamlining and simplifying compensation claims handling.⁵

Transition seminars and services

6.5 The Returned & Services League of Australia (RSL) highlighted the disparity between the intensity and length of training provided to members when joining the ADF compared to the training provided when they leave. The RSL noted that positive transition experiences are linked to mentors who can guide and sometimes 'forcefully encourage' veterans to actively engage in the transition process:

A number of veterans have spoken of the intensity and length of their initial training in Defence compared with the much reduced two-day transition seminar when leaving. Veterans report transition experiences ranging from positive and successful to poor. Successful transition appears to often be linked to a mentor or individual in Defence who is encouraging, helpful and at times forcefully encourages the veteran to actively engage in the process and complete the necessary tasks prior to discharge.⁶

6.6 The Australian Psychological Society also commented on the importance of providing adequate time and guidance to transitioning members, noting that the intensity and volume of the two-day transition seminars provided by Defence can be overwhelming and make it difficult for transitioning members to retain and understand the information they are being presented:

These transition seminars take place over two days and provide a variety of information such as job search strategies, personal wealth creation, financial planning, private health insurance etc. APS members report the volume and intensity of the information provided at these seminars is potentially overwhelming making it difficult for participants to retain and understand priorities. In addition these seminars do not currently include representatives from all aspects of the service system - for example, hospital based services are not invited to present. It is suggested these

5 Department of Veterans' Affairs, *Submission 35*, pp 29–30.

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

transition seminars could be improved by staging the information over a period of time with additional support such as guidance personnel.⁷

6.7 Defence informed the committee that the two-day Transition Seminar aims 'to ensure members and their families are well informed and encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning'. Joint Health Command have developed the LifeSMART presentation, given during the Transition Seminar, which aims 'to increase members' psychological resilience and develop awareness of better ways of coping with the challenges of transition to civilian life'.

6.8 Defence noted that members are 'required to finalise their arrangements well before their date of separation from the ADF' and that administrative management and support are provided by Regional ADF Transition Centres. Members can also access the ADF Transition Handbook, which provides transition information and support online. Furthermore, the Directorate of National Programs in the Defence Community Organisation provides services to 'ensure that ADF personnel and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning'.⁸

6.9 DVA advised that the Veterans and Veterans Families Counselling Service (VVCS) Transition Program, 'Stepping Out', is available prior to separation and can be accessed up to twelve months after separation.⁹ Stepping Out is a two-day voluntary program offered to all transitioning ADF members and their partners and focuses on the 'transition process and what it means to go from military life to civilian life as an individual and as a family – in both practical and emotional terms'.¹⁰ DVA noted that it recently launched the High Res website and mobile application (replacing the Wellbeing Tool Box), which provides self-help tools and interactive learning resources for ADF members, veterans, and their families.¹¹

On Base Advisory Service

6.10 Defence advised that serving and discharging ADF members can seek advice and information about DVA support services and are encouraged to lodge compensation claims early at On Base Advisory Services (OBAS), which are available on over 44 Defence bases across Australia.¹² DVA told the committee that the OBAS officers are 'selected for their experience and understanding of DVA

7 Australian Psychological Society, *Submission 22*, p. 13.

8 Department of Defence, *Submission 34*, p. 18.

9 Department of Defence, *Submission 34*, p. 18.

10 Department of Veterans' Affairs, Veterans and Veterans Families Counselling Service, *Stepping Out (Transition Program)*, <http://www.vvcs.gov.au/Services/GroupPrograms/stepping-out.htm> accessed 18 February 2016.

11 Department of Veterans' Affairs, *Submission 35*, p. 29.

12 Department of Defence, *Submission 34*, p. 18.

entitlements and processes¹³ and that the uptake of the OBAS has steadily increased since its implementation in October 2011 (see table 5.1).¹⁴

Table 6.1 – National Uptake of On Base Advisory Services

	2012-13	2013-14	2014-15
Enquiries*	8,869	13,548	14,145
New Client to DVA**	2,777	4,162	4,781
Enquiries relating to medical discharge	1,134	2,145	2,349

*Enquiries relate to face to face interviews, email and phone contact and are a result of various factors including but not limited to multiple client visits, client's registering for qualifying service only, following up post-claim issues.

**A new client to DVA is an Australian Defence Force member who does not appear on any DVA system.

Department of Veterans' Affairs, answer to question on notice, 21 September 2015, (received 13 November 2015).

Rehabilitation, education and re-skilling

6.11 A number of submissions highlighted the importance of providing ADF members with adequate rehabilitation, education and re-skilling to ensure that recovery and reintegration into civilian life is successful.¹⁵ Soldier On stressed the importance of education and re-skilling for veterans' rehabilitation and positive mental health outcomes, noting that many ADF members have not engaged with employment in any sector other than the ADF:

Many of our serving and ex-serving men and women will have joined the services at a young age, and have not engaged with employment in any sector other than the ADF. Applications, skills requirements, and processes and procedures are all significantly different. For any veteran the transition is a challenge, but for those dealing with a mental health issue, it can be near impossible to tackle alone.

In tooling our ex-serving man and women for the civilian workforce, we will be able to give them a positive start in their life after service. Some veterans may not be able to work full time, but giving them the opportunity to study, to work part time, to keep their minds active and to contribute to

13 Department of Veterans' Affairs, *Submission 35*, p. 50.

14 Department of Veterans' Affairs, answer to question on notice, 21 September 2015, (received 13 November 2015).

15 For example: Veterans Care Association, *Submission 4*, p. 2; Returned and Services League of Australia, *Submission 19*, pp 18–19; Solider On, *Submission 29*, p. 11; Alliance of Defence Service Organisations, *Submission 40*, pp 10–11; Royal Australian Regiment Association, *Submission 46*, pp 8–9; Royal Australian Armoured Corps Corporation, *Submission 59*, pp 10–12; KCI Lawyers, *Submission 71*, p. 10; Australian Peacekeeper & Peacemaker Veterans' Association, *Submission 78*, pp 7–9.

their family and their community will only have positive outcomes for their rehabilitation.¹⁶

6.12 Soldier On also told the committee that there are inconsistencies and confusion regarding the rehabilitation, education, and re-skilling services that are available to veterans, recommending that a consistent transition process be made available to all when they leave the ADF:

It is recommended that a universal transition program is developed for all those departing from the ADF, so that at the very least these men and women have the capability to find meaningful work after their service.

For those with mental health issues, current offerings through DVA don't allow flexibility to change courses, or for up-skilling once a course has started. This means there is less chance of meaningful employment as a result of this study, and more chance of leaving a job and staying unemployed for a long period of time...there are also issues around awareness, with many veterans not understanding how much they can study, how long they can work, how much they can access in study support, and whether or not they are in any way eligible.

It is recommended that this process is simplified and made easier to understand. A simple document should also be developed to highlight who is eligible to study without affecting their entitlements, how long ex-serving men and women can work/volunteer each week without an impact on their entitlements, and who can access what level of study support in order to up-skill for the civilian workforce.¹⁷

6.13 KCI Lawyers advised the committee that DVA provides 'vertical rehabilitation' that disadvantages junior-ranked members by only allowing veterans to undertake rehabilitation based on the level of education, experience and employment they held prior to their injury or mental ill-health:

DVA will not provide rehabilitation to assist and retrain a member to a new level of education with the potential to obtain employment with tertiary or similar type education if they did not exhibit such a potential prior to their injury. Worse still is DVA terminating a Veteran's incapacity payments on the basis that if they undertake tertiary education' without permission' i.e. assessed by DVA and determined to be suitable and appropriate, then they must have a 'capacity to earn' by undertaking further education.

This is in contrast to former ADF Officers/Veterans who, having undertaken and achieved tertiary education are offered and provided with additional tertiary education which includes postgraduate degrees like MBAs and similar type education opportunities. That is, if they have shown a capacity to undertake tertiary education then they are eligible for

16 Solider On, *Submission 29*, p. 11.

17 Soldier On, *Submission 29*, p. 11.

additional tertiary education by DVA to be accepted as a rehabilitation program.¹⁸

6.14 This was also raised by the Australian Peacekeeper & Peacemaker Veterans' Association, commenting that this this contravenes the whole-person approach to rehabilitation and thwarts the objectives of psychosocial rehabilitation:

We are aware that the [Military Rehabilitation and Compensation Commission] is rejecting veterans' applications for vocational or tertiary education. Accepting that the evidence is anecdotal, two [Commission] Delegates are alleged to have said: You're a soldier and don't have the brains to go to university, and you don't need that TAFE course, there's no job available.¹⁹

6.15 DVA told the committee that rehabilitation programs are tailored to meet the individual needs of veterans after discharge, taking medical, vocational, psychosocial, and educational factors into account. Rehabilitation programs can include medical; dental; psychiatric; in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars. DVA advised that clients can be referred and assessed for rehabilitation once their liability claim has been accepted:

The process for receiving rehabilitation begins with the client submitting a liability claim to DVA. Once a claim is accepted, a needs assessment is conducted to determine what services are suitable and available to the client. Where appropriate, the client is referred for rehabilitation. Following referral, a DVA rehabilitation coordinator will organise a third-party rehabilitation provider to organise further assessment and preparation of a rehabilitation plan. Concurrent to the rehabilitation process, a client may also receive medical treatment and financial support such as incapacity payments and permanent impairment compensation.²⁰

6.16 DVA advised the committee that there has been an overall growth in rehabilitation activity in recent years (see table 5.2) and that the 2015-16 budget funded an enhancement of the Veterans' Vocational Rehabilitation Scheme, providing \$200,000 in 2015-16 and a total of \$700,000 over the forward estimates to improve the scheme's operation.²¹

18 KCI Lawyers, *Submission 71*, p. 10.

19 Australian Peacekeeper & Peacemaker Veterans' Association, *Submission 78*, p. 7.

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

21 Department of Veterans' Affairs, *Submission 35*, pp 33–34.

Table 6.2–Rehabilitation activity by DVA (assessments completed)

	2009-10	2010-11	2011-12	2012-13	2013-14
<i>Safety, Rehabilitation and Compensation Act 1988</i>	944	988	1124	1113	830
<i>Military Rehabilitation and Compensation Act 2004</i>	475	557	765	1025	1132
Veterans' Vocational Rehabilitation Scheme	106	116	111	88	123
Total	1525	1661	2000	2226	2085

Department of Veterans' Affairs, *Submission 35*, p. 33.

6.17 DVA noted that it has also recently implemented a number of improvements to ensure continuity of care for ADF members and smooth transition from ADF rehabilitation services to DVA rehabilitation providers:

...changes have been made to the coordination and communication between DVA and the ADF Rehabilitation Programme to facilitate the transition of separating ADF members from this Programme to DVA's rehabilitation arrangements. ADF personnel already undertaking a rehabilitation plan with established goals in place are continued in the DVA environment, including, where possible, use of ADF rehabilitation providers to ensure an unbroken provider support environment for clients.²²

6.18 DVA advised the committee that it has recently 'completed a number of ongoing business improvement activities' to improve quality of support, provider knowledge, and coordination of its rehabilitation program. This includes a range of new communication materials and stakeholder education with staff, rehabilitation providers and clients including:

- publishing an online rehabilitation e-learning package for clients and providers;
- publishing rehabilitation success stories to promote rehabilitation pathways;
- developing a new provider newsletter;
- upgrading DVA's rehabilitation website;
- launching a new social media campaign;
- publishing a rehabilitation online brochure and information pack; and

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

- developing an active liaison and communication program with key stakeholders including defence welfare groups and DVA's On Base Advisory service.²³

6.19 DVA informed the committee that the Veterans Employment Assistance Initiative was launched in September 2014. The initiative aims to 'help injured former ADF members reclaim independence, realise their skills and capabilities, and achieve their vocational rehabilitation goals post-service'. DVA advised that the initiative focuses on three key areas:

- enhanced vocational rehabilitation arrangements;
- employer engagement; and
- early engagement with clients through the ADF Rehabilitation Programme.

6.20 The first stage of the initiative was a six-month pilot conducted in South East Queensland from September 2014 to February 2015. The pilot aimed 'to monitor and evaluate the enhanced approach to vocational rehabilitation to ascertain the strengths of the approach and identify any improvements that could be made, DVA advised that, whilst the evaluation of the pilot is currently underway, initial indications are that it has been successful.²⁴

6.21 DVA also informed the committee of the MRCA Rehabilitation Long-Term Study project. It is a joint DVA and Defence project which will 'examine the effectiveness of rehabilitation arrangements under MRCA within both the ADF and DVA, over the long term'. DVA advised that the project is in its early planning stage and will 'provide Defence and DVA with a clear understanding of the effectiveness of current rehabilitation programmes and services and an improved understanding of the client group'.²⁵

Continuity of support and transfer of responsibility of care from ADF to DVA

6.22 A number of submissions criticised the transfer of responsibility of care from ADF to DVA.²⁶ Phoenix Australia acknowledged that is 'considerable collaboration' between the ADF and DVA for members who have been identified as physically or psychologically unwell in the period before discharge, but 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'. Phoenix Australia noted that these

23 Department of Veterans' Affairs, *Submission 35*, p. 34.

24 Department of Veterans' Affairs, *Submission 35*, p. 34.

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

26 For example: Mr Robert Shortridge, *Submission 16*, p. 14; Returned & Services League of Australia, *Submission 19*, p. 16; Mr Robert Shearman, *Submission 21*, p. 3; Australian Psychological Society, *Submission 22*, p. 13; Soldier On, *Submission 29*, p. 11; Phoenix Australia, *Submission 30*, p. 10; Legacy Australia, *Submission 39*, p. 4; Royal Australian Regiment Association, *Submission 46*, p. 4; Slater & Gordon Lawyers, *Submission 51*, p. 18; KCI Lawyers, *Submission 71*, pp 8–9.

veterans may 'fall through the gap' suffering a steady deterioration in mental health and functioning to the point of substantial disability before they eventually seek help.²⁷

Memorandum of Understanding

6.23 In February 2013, Defence and DVA signed the *Memorandum of Understanding for the Cooperative Delivery of Care and Support to Eligible Persons* (MoU).²⁸ The MoU is intended to 'ensure that eligible wounded, injured or ill ADF members, and their families, are supported and cared for during and after their service'.²⁹ Other principles of the MoU include ensuring that:

- the framework of care and support, spanning both Defence and DVA is enduring;
- Defence and DVA provide other support and Services as may be agreed from time to time and as set out in the MoU;
- the funding arrangements that support the rehabilitation of members are defined and understood;
- communication with wounded, injured, or ill ADF members, and supporting agencies, will reflect the joint responsibilities of Defence and DVA;
- governance arrangements will facilitate collaborative policy and program development and allow for engagement on emerging issues affecting both Defence and DVA; and
- Defence and DVA's respective, and joint, responsibilities for the support of wounded, injured, or ill current and former members are measured and reported.³⁰

6.24 The RSL criticised the MoU, describing it as 'a very prosaic attempt to outline how two Federal Government Departments should attempt to co-exist when both are hamstrung by a third organisation, the Department of Finance'. The RSL emphasised that the MoU 'needs more rigour in relation to transition; it needs a better system of ensuring that the individual is not discharged from the ADF prior to their entitlements being satisfied'.³¹ In addition, the RSL asserted that:

- the operating principles, as written, are not being adhered to;

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

28 It should be noted that in November 2013 the *Memorandum of Understanding* was updated to remove reference to veterans.

29 Department of Defence and Department of Veterans' Affairs, *Memorandum of Understanding for the Cooperative Delivery of Care and Support to Eligible Persons*, p. 8.

30 Department of Defence and Department of Veterans' Affairs, *Memorandum of Understanding: Cooperative Delivery of Care and Support to Eligible Persons*, version 1.1, November 2013, pp 8–10.

31 Returned & Services League of Australia, *Submission 19*, p. 16.

- too many people are being discharged from the ADF on medical grounds before DVA has determined their claim;
- the effectiveness of the support continuing using agreed metrics and feedback from current and former ADF members is not being conducted and/or published;
- co-operation 'in real terms' between Defence and the ex-service community 'has been limited in the extreme';
- the schedules outlining the provision of services are inaccessible; and
- communication management between Defence and DVA 'remains cosmetic' for those stakeholders not in either Defence or DVA.³²

6.25 Defence assured the committee that 'Defence and DVA maintain a strong, coordinated and effective relationship' under the MoU. Defence noted that the MoU provides for oversight of the normal interaction of the two departments as well as facilitating the development of joint initiatives. Defence noted that each department is aware of, and can contribute to, key initiatives that are being progressed independently by each department.³³ DVA informed the committee that the MoU has 'been effective in ensuring that both Departments consider and respond to issues impacting upon the care and support of current and former ADF members'.³⁴

Gaps in support

6.26 The Australian Psychological Society reported that it 'can often take from six weeks to six months for some veterans to access income from their superannuation or pension', noting that 'this creates clear barriers for veterans in obtaining accommodation, other important capital expenditure decisions and creates barriers for essential functions like daily living'.³⁵ The RSL advised the committee that this can be especially detrimental for veterans who are not medically discharged, but find themselves unable to work due to mental or other illness:

Financial difficulty can be even more pronounced for veterans who are not medically discharged, but subsequently find themselves unable to work due to mental or other illnesses. Delays in claims processing may drag on for six months or longer. It can for example, take the DVA many months just to ascertain that a veteran served in the ADF, let alone process their injuries. During this time the veteran will receive no income, and may not be able to access medical services.³⁶

6.27 The committee received evidence from Miss Alanna Power and her partner, Mr Ryan Geddes (a veteran combat engineer who served in Afghanistan and who

32 Returned & Services League of Australia, *Submission 19*, p. 16.

33 Department of Defence, *Submission 34*, p. 16.

34 Department of Veterans' Affairs, *Submission 34*, pp 22–23.

35 Australian Psychological Society, *Submission 22*, p. 13.

36 Returned & Services League of Australia, *Submission 19*, p. 14.

struggles with PTSD anxiety and depression as a result of his service) regarding the hardships of transition and the lack of support available. Miss Powers and Mr Geddes described it as a slow and difficult process which placed significant personal, financial, and emotional strain on their family:

...when he was finally diagnosed with PTSD, anxiety, depression...That was when he first contacted DVA. That was when he started going through that claims process of, you know, are they going to accept liability, are they not? Obviously he could not work. He had medical certificates saying that he was not fit for employment in any capacity. But still, we did not get any financial support whatsoever. Once DVA did finally admit liability, which was nine months later, they turned around and said, 'We'll pay him minimum wage', which really is not much, 'until we know if ComSuper is going to recognise his claim and pay out on that.'

We were told by ComSuper it would take six weeks to sort of look at all his medical documents and all of that and make a decision...So it was supposed to take six weeks to get the medical documents. It took nearly five months. When that finally happened, DVA have said, 'Yes, we will pay you the correct rate', which only gives 100 per cent of your wage for 52 weeks, and then after that, with medical documentation, it drops down to 75 per cent. So you have that side of dealing with DVA, which is, I guess, your incapacity payments, they are called, which is like your wage, and the other side of dealing with DVA is also your payout, your compensation. For us, that was probably the hardest part. It is a lot of paperwork to submit. They lose a lot of paperwork. They do not help you in any way. You always have to reach out to them to find out what is happening with your claim, which I think is a bit unfair. You cannot expect someone who is mentally ill to be following up with DVA on a weekly basis to make sure that someone is doing their job properly.³⁷

6.28 The Chief of the Defence Force (CDF), Air Chief Marshal Mark Binskin AC, assured the committee that there are a number of programs in place to address gaps so that 'there is no chasm that sits between the two organisations'. However the CDF noted that, despite this, and despite encouragement from Defence to contact DVA during transition, members who do not have an identified medical condition often do not realise that they need assistance until after they have already left Defence, resulting in the potential for a gap between Defence and DVA support:

In transitioning someone out, the minute they start to transition we have the transition centres on the bases to be able to help them. As you know, it is the paperwork myriad to step through. There are programs there to help them transition. As we start to transition them out, very early on we make sure they are put into contact with DVA. As I said earlier, 33 per cent do not want that. We need to work around why that is the case.

If someone has of recognised medical issue—a physical or mental issue—as they transition, that transition occurs across to DVA. That is handed to DVA. Where we find issues arise is: for people do not have a declared

37 Miss Alanna Powers, *Committee Hansard*, 31 August 2015, p. 67.

medical condition, their transition out is the point that they realise, 'Oh, now I don't have that whole structure around me—that support network that I needed.' Issues start to come to the fore. Then they need to go into the DVA process after having come out of Defence. What we are trying to do up-front with as many people as we can is to get them to understand that, if they think they have an issue, we need to address it before they come out of Defence. Then we can hand them to DVA. There are a number of programs in place to improve that so that there is no chasm that sits between the two organisations.³⁸

6.29 Mr Shane Carmody, Chief Operating Officer of DVA, told the committee that DVA is working with Defence to engage ADF members during transition and process their claims as quickly as possible to ensure a smooth and effective transition:

We are also very focused on transition. Clearly, we work very closely with Defence in trying to identify members and to ensure that members transition as effectively as they can. Continuity of care, particularly for those under treatment, is really important to us. As the CDF, there are people who leave, administratively or for other reasons, who do not make contact with us and need to make contact with us later. That is something that we are working very hard on to see whether we can reduce the number of people who opt out from contact with us when they leave, and to find if any mechanism we can to continue to engage with them to see whether we can meet their needs. It would be good if we could get their claims processed as quickly as we can and try to ensure that their transition is smooth. That is not always the case. But we are working very, very closely together on the Support for Wounded, Injured and Ill Program and various other programs to try to make the transition effective.³⁹

Veteran homelessness

6.30 The committee received a number of submissions regarding veteran homelessness.⁴⁰ Phoenix Australia advised the committee that 'veterans with PTSD and other mental health problems will be at greater risk of becoming homeless.'⁴¹

38 Air Chief Marshal Mark Binskin AC, Chief of the Defence Force, Department of Defence, *Committee Hansard*, 21 September 2015, pp 17–18.

39 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 18.

40 For example: Mr Douglas Steley, *Submission 6*, p. 6; Mr Robert Shortridge, *Submission 16*, pp 4–5; Walking Wounded, *Submission 18*, pp 4–5; Returned and Services League of Australia, *Submission 19*, pp 11, 14–15, 25–41; Australian Psychological Society, *Submission 22*, pp 10–12; Dr Kieran Tranter, *Submission 27*, pp 30–40; Soldier On, *Submission 29*, pp 8–9; Phoenix Australia, *Submission 30*, p. 9; Alliance of Defence Service Organisations, *Submission 40*, pp 2, 4–5; Name withheld, *Submission 43*, p. 2; Royal Australian Regiment Association, *Submission 46*, p. 2; Slater & Gordon, *Submission 51*, pp 13–15; Royal Australian Armoured Corps Corporation, *Submission 59*, p. 4–6; Young and Well Cooperative Research Centre, *Submission 62*, pp 7–8; Dr Kevin Kraushaar, *Submission 64*, p. 12; Name withheld, *Submission 70*, pp 5–6; KCI Lawyers, *Submission 71*, p. 6; Mr Phil Hay, *Submission 72*, pp 1–9; Name withheld, *Submission 79*, pp 1–5.

41 Phoenix Australia, *Submission 30*, p. 9.

DVA noted that homelessness is very difficult to quantify and that it is working with the Australian Institute of Health and Welfare regarding improving data collection and working with Homelessness Australia to identify homeless veterans:

...we are trying to do to get a better handle on the numbers, we have got a couple of things in train. One is that we are working with the Australian Institute of Health and Welfare to refine the questions that are in the housing and homelessness data collection that is run periodically so that we get a better definition of what a veteran is and a better understanding from that collection about the number of veterans who are accessing specialist homelessness services.

We also have started to work with Homelessness Australia to see whether we can get information out to homelessness organisations about the services that DVA offers and get them to identify veterans who are accessing their services and refer them to us. But also they periodically do what they call a rough sleepers census, and we are looking at whether we can link in with them when they do those censuses to see whether we can identify veterans.⁴²

6.31 DVA advised the committee that 'the current estimate of homeless veterans is likely to be in the order of 200-300 Australia-wide'.⁴³ This number was disputed by the RSL, which criticised DVA, noting that 'already this year the DVA has cut its own estimates of at least 3,000 homeless veterans in 2009, to 300 in 2015'.⁴⁴ Mr Carmody explained that the difference in numbers was related to differences in definition of both veteran and homelessness:

There is a definitional issue: it is a question of risk of homelessness versus rooflessness—if I can put it that way—people who do not have anywhere to stay. Our difficulty with the figure that was in the survey of 2009 was that it was extremely broad, including people at risk of homelessness, people who were couchsurfing and quite a range of reasons. We ran our demographic against that number and came up with a smaller figure.⁴⁵

6.32 DVA also advised the committee that the provision of housing 'is not within our portfolio responsibility'.⁴⁶ DVA noted that, when it receives a report of a homeless veteran, it can provide the following assistance:

- referral to local homelessness agencies to assist with an immediate accommodation solution;

42 Ms Sue Campion, First Assistant Secretary, Health and Community Services Division, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 22.

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

44 Returned & Services League of Australia, *Submission 19*, p. 28.

45 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 22.

46 Mr Shane Carmody, Chief Operating Officer, Department of Veterans' Affairs, *Committee Hansard*, 21 September 2015, p. 23.

- referral to the VVCS, which can offer support to connect with local ex-service organisations offering long term assistance;
- investigation by a senior DVA staff member to ensure that the veteran is receiving all benefits and entitlements to which they are entitled;
- referral to Centrelink to assess potential for benefits or for further support; and
- arranging for changes in income support payments if this would assist a client in need.⁴⁷

Homes for Heroes

6.33 The RSL told the committee that the Homes for Heroes Program, originally established by RSL Lifecare in March 2014, is a comprehensive rehabilitation service that is available to 'veterans of any conflict, ex-servicemen and women and the families of those cohorts; providing they are genuinely homeless'.⁴⁸ The RSL noted that the Homes for Heroes Program is only in its early stages and has only just begun to publicise the program. Nonetheless, it has housed over 71 veterans. Mr Geoff Evans, the Ambassador and Founder of Homes for Heroes, explained that homelessness is not limited to veterans living on the streets:

When we talk about homeless veterans, we are not talking about people who are living rough on the streets. Of the 71 veterans that we have housed, only a fraction of them had been living rough—perhaps half-a-dozen. I cannot remember the exact number. But many of them are living in cars, couch-surfing and things like that. So 'homeless' implies that they are without a home, not without a house. Our experience is that veterans will not access mainstream homelessness services, particularly when they are young, because in the main it is too much of an admission of how far they have fallen.⁴⁹

6.34 The committee spoke to a number of homeless veterans who were receiving assistance from Homes for Heroes. One submitter told the committee that Homes for Heroes saved their life:

Since being here, I hear the term sleeping rough to describe someone who is homeless. But that doesn't do it justice. You're not camping. 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.

Having just gone through the darkest, lowest point in my life I can't express the feeling I had having a shower and going to bed on that first night. So

47 Department of Veterans' Affairs, *Submission 35*, p. 51.

48 Returned & Services League of Australia, *Submission 19*, p. 27.

49 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 1.

aside from the fact that Homes for Heroes saved my life, I want to bring to the attention of the committee why the structure of this organization provides an excellent model for other similar organizations to facilitate the recovery of ex-servicemen and women suffering mental illness.⁵⁰

6.35 Mr Gray Norman, a former infantry soldier, told the committee that he was injured during service, which resulted in a 'permanently damaged degenerative spine with a lot of nerve damage'. Mr Norman told the committee that 'they wanted to medically discharge me while I was still in the battalion' but that he sought legal advice and was treated very poorly as a result. Mr Norman said that he left Defence and transitioned into work and was eventually granted a Gold Card but that by this stage he was already on the path to homelessness:

By that time, my marriage had disintegrated completely. I had to leave the married home because I was not going to put my wife and my daughter through the torment. I knew my injuries were getting worse, because by that time I was consumed by pain medication. I was taking a lot of OxyContin and Tramadol. I was a dribbling mess and I became an isolated alcoholic in a unit. At the time—this is going back 11 years ago—I would go along to DVA or sub-branch meetings. Most of the guys were 30 or 40 years my senior, and at the end they would have cucumber sandwiches with the crusts cut off. There was nothing for me; there was nothing for a person my age. As I said, it degenerated to where I just went to hospital and got pumped up with as much medication as I could, just to take the pain away. Family was a distant memory.

I went down the housing pathway. I couch-surfed for 2½ years because supposedly I was on the top of the list. I was quite excited when I was called in. But all they called me in for was to say, 'Your pension is now above the monetary threshold, so you're no longer on our books.' Being on the gold card, I can apply for housing assistance, but they take dollar for dollar, so there is no point in me actually asking for any assistance when it comes to housing. It came to the point that last year I went back into hospitals again, basically because I was homeless. I had nowhere to go, so I went to hospital for accommodation. I had long stopped taking pain medication for my injuries, but I never put the drink down and I was a dribbling alcoholic. Upon discharge I was living in the back of my car, at the back of a pub. I cannot recall exactly how I got to know about Homes for Heroes; I just know that there were a couple of phone calls made. I arrived there and within about three or four days I was sent to St John of God. I thought that was a chance to actually turn my life around, so I took that with both hands. Upon my return I started volunteering within the office and that is where I have been ever since.⁵¹

6.36 Homes for Heroes advised the committee that 'one hundred percent' of its residents suffer from mental illness and that 'substance abuse and addiction problems are prevalent, most are wounded or injured and most arrive with no possessions at

50 Name withheld, *Submission 79*, p. 3.

51 Mr Gary Norman, *Committee Hansard*, 18 November 2015, p. 14.

all'.⁵² Mr Evans told the committee that family breakdown is 'ubiquitous' and some homeless veterans are simply without an income while they wait for DVA to process their claims:

Family break down is ubiquitous. We take a lot of calls from wives and mothers who will have had a loved one go to war and come back a totally different person. They will say things like, 'I love them; I want them to stay here, but they become violent or abusive and they just cannot stay. Can you take them?' Those calls, in particular, are the most horrendous. The partners did not sign up to go to war, but nobody is supporting them. Even with the Department of Veterans' Affairs, remember, the client is the veteran—not the family member.

Others experience financial problems. We have had incidents where people have been discharged from Defence, medically, and the Department of Veterans' Affairs have only paid four weeks post discharge but it has taken many months to process their pension claims. So they end up, for a long period of time, without an income.⁵³

6.37 Mr Evans noted that many veterans who have been receiving in-patient mental health treatment, provided by DVA, are frequently discharged after treatment without a follow-up plan, 'discharged into the ether':

...one of the most common pathways into homelessness is when a veteran goes into a private clinic, under the Department of Veterans' Affairs—and some of these clinics can charge up to \$1,000 a day—when they discharge there is no follow-up plan. They go in acutely symptomatic and get a sustained period of treatment. They become well again whilst they are in that structured environment. Then they are discharged into the ether. It is only a matter of time when they completely fall over—again—and go back into hospital.

One of our residents, here, has been through that cycle 18 times—possibly 16, but I think it is 18 times that he has been in and out of clinics—for a four-week stay each time at the cost of around \$1,000 a day. The average number of admissions to private mental-health service providers is four times each. But when they are discharged there is no screening tool to ask them, 'Where are you going? What is the follow-up support you are going to get?' And it becomes a revolving door. That should be fairly easily fixed with the contracts that are provided by the Department of Veterans' Affairs, because DVA purchases these services from the health providers. The terms of the contract should stipulate that follow-up care needs to be provided, but they are currently not.⁵⁴

52 Returned & Services League of Australia, *Submission 19*, p. 27.

53 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 1.

54 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 2.

6.38 Mr Lee Sarich, a veteran at Homes for Heroes, told the committee of his experiences being discharged into homelessness:

As a result of the PTSD I ended up homeless. It was a very difficult time. I almost killed myself a year and a half ago. It is hard to briefly explain what that was like and how that ended. About 18 months ago I came across this program and started getting some PTSD treatment. Whilst getting treatment for PTSD I heard about the Homes are Heroes program. I was one of those guys that went into a hospital on the Gold Coast and as a veteran got treated anxiety and depression and then left the hospital homeless—it just seems a little bit absurd. Sometime later I came down to Sydney and went into the St John of God Hospital and got treated for PTSD. I would have left their homeless as well, and effectively did, other than at the time the informal kind of arrangement of the Homes for Heroes program. I moved out here just over 12 months ago. I have been here as a resident for 12 months. I have been undergoing treatment and rehabilitation for PTSD since I have been here.⁵⁵

6.39 Homes for Heroes asserted that there are 'two crucial and mutually reinforcing aspects' to ending homeless (1) the provision of safe, secure, and stable housing; and (2) ongoing case management.⁵⁶ Homes for Heroes takes the 'housing first' approach, which asserts that, for a person experiencing homelessness, the primary need is to obtain stable housing, and that other issues, such as mental ill-health and substance abuse and that may affect them can and should be addressed once housing has been obtained. Mr Evans explained that:

What we do is look at the individual and start wrapping the services they need around them—psychological support, social support, employment support or anything they need. The Department of Veterans' Affairs could do that if they allocated a proper caseworker to the individual and then assisted them once they were discharged. Ideally, the caseworker would know when they went into hospital and when they went out. They would follow their progress, and whatever support they needed the department would provide, along the same lines as what a social worker would do.⁵⁷

6.40 Mr Evans noted that whilst support services for veterans exist, 'by the time they become homeless they are too unwell to access them', explaining that veterans struggling with mental ill-health, or otherwise at risk of homelessness, need someone to coordinate and manage their care:

The support services that the veterans need exist, but by the time they become homeless they are too unwell to access them. They cannot ring a doctor and make an appointment and then get to the appointment and see them. If you are suffering from severe depression, you cannot even get out of bed. They just cannot tie it all together. They need someone to do that for

55 Mr Lee Sarich, *Committee Hansard*, 18 November 2015, p. 9.

56 Returned & Services League of Australia, *Submission 19*, p. 41.

57 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 4.

them until they are back on their feet—and then manage them along and, if they have a little slip along the way, be there for them to plug them into the appropriate services provided. It just does not happen. If you had someone there to provide that service and tie it all together, very few veterans would end up homeless, because the key to being homeless is poor mental health.⁵⁸

6.41 The RSL advised that 'it is forecast that RSL Lifecare will spend over \$2 million of its own funds over the next three years to provide accommodation, support and reintegration services to homeless veterans'. Mr Evans informed the committee that the estimated cost to house and provide psychosocial services to a veteran at Homes for Heroes is approximately \$20,000 per annum. Mr Evans acknowledged that the provision of housing is outside of DVA's portfolio responsibilities but asserted that 'what they should be providing is complex psychosocial care management' services similar to those provided by Homes for Heroes.⁵⁹

Committee view

6.42 Discharge is a critical time for ADF members, with the committee receiving considerable evidence that poor transition experiences are linked to poor reintegration, poor mental health outcomes, and, if left unchecked, can lead to homelessness and even suicide. The committee acknowledges the support provided during medical discharge and commends Defence and DVA for its *Support for Wounded, Injured or Ill Programme*, which provides support for personnel from the point of injury through to ongoing support after military service. The committee also commends Defence and DVA for its On Base Advisory Service and notes the steady increase in uptake.

Transition seminars and services

6.43 However, the committee is concerned about the level of transition support and services offered to ADF members who are not medically discharged.

6.44 The committee notes the comments made by submitters regarding the intensity and length of training provided to members when they join the ADF compared to the training provided when they leave. The two-day transition seminars provided by Defence may be comprehensive; however, the committee is concerned by evidence that this process can be overwhelming and the information difficult to retain and understand. The committee does not believe that Defence has discharged its duty to guide and inform its members through the transition process after providing a two-day transition seminar.

6.45 The committee notes the evidence that positive transition experiences are linked to mentors who can guide and 'forcefully encourage' veterans to actively engage in the transition process. The committee believes that Defence should work

58 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 4.

59 Mr Geoff Evans, Ambassador and Founder, Homes for Heroes, RSL Lifecare, *Committee Hansard*, 18 November 2015, p. 4.

together with ex-service organisations to develop a transition mentoring program. The program would provide volunteers from within the ex-service community with baseline training regarding transition, services available to veterans, and common problems with reintegration. During the transition process, every veteran should be connected to a trained mentor to assist and guide them through the transition process as well as providing an ongoing point of contact for any questions or concerns they may have.

Recommendation 14

6.46 The committee recommends that the Department of Defence work with ex-service organisations to develop a transition mentoring program, which will connect every veteran with a trained mentor from the ex-service community to assist and guide them through the transition process.

Rehabilitation

6.47 It is essential that ADF members and veterans are provided adequate rehabilitation, education and re-skilling to ensure that recovery and reintegration into civilian life is successful. The committee acknowledges that rehabilitation programs are tailored to meet the individual needs of veterans after discharge, taking medical, vocational, psychosocial, and educational factors into account. However, the committee is concerned by evidence of inconsistencies and confusion regarding rehabilitation and evidence of policies that disadvantage junior-ranked members by only allowing veterans to undertake rehabilitation based on the level of education, experience and employment they held prior to their injury or mental ill-health. The committee believes that all ADF members should be given the opportunity to access rehabilitation, education and re-skilling to ensure that recovery and reintegration into civilian life is successful, regardless of rank.

Recommendation 15

6.48 The committee recommends that the Department of Veterans' Affairs review its rehabilitation assessment policy to ensure that junior-ranked members are not disadvantaged and all veterans are able to access rehabilitation, education, and re-skilling based on their individual needs and abilities and regardless of rank.

Continuity of support

6.49 The committee is concerned by evidence of gaps in support for veterans who are not medically discharged but find themselves unable to work due to mental or other illness. The committee notes Defence and DVA's assurances that there are a number of programs in place to address gaps so that 'there is no chasm that sits between the two organisations' and acknowledges the challenge of assisting veterans, who, despite encouragement from Defence to contact DVA during transition, may not need or realise that they need assistance until after they have already left Defence, resulting in the potential for a gap between Defence and DVA support. Nonetheless, the committee believes that more must be done to bridge these gaps and provide support and assistance to veterans whilst claims are being processed.

Veteran homelessness

6.50 The committee acknowledges that the provision of housing is not within DVA's portfolio responsibility; however, this does not discharge DVA of its obligation to support veterans and assist them to access one of the most basic human needs, stable housing. Furthermore, the committee recognises the challenges of accurately quantifying the number of veterans who are homeless; however, the committee is troubled by the narrow definition of homeless that DVA has recently employed, which may inadvertently downplay the seriousness of the issue. The introduction of a universal identification number and identification card for veterans should assist in the identification of veterans who are homeless. This would also assist homeless support services to identify veterans and connect them to DVA and other appropriate veteran support services.

6.51 The committee is very concerned by evidence that veterans who are receiving in-patient services for mental ill-health are being discharged into homelessness and often on more than one occasion. This is a significant dereliction of duty of care for both the mental healthcare provider and DVA, as the purchaser of the services. Veterans whose mental health has deteriorated to the point of receiving in-patient care should be identified by DVA as at risk of homelessness and be provided with ongoing psychosocial management. This should include the provision of an ongoing psychosocial case manager to actively manage a veteran's care program until their mental health and living situation is stable.

Recommendation 16

6.52 The committee recommends that the Department of Veterans' Affairs identify veterans who are receiving in-patient mental health care as at risk of homelessness and provide an ongoing psychosocial case manager to actively manage an 'at risk' veteran's care program until their mental health and living situation is stable.

6.53 The committee commends RSL Lifecare for its Homes for Heroes Program and the work of its founder, Mr Evans. Despite being in its early stages, the program's 'housing first approach' and focus on ongoing psychosocial support for veterans appears to be achieving excellent results at minimum cost. The committee agrees that the key elements for addressing veteran homelessness is the provision of safe, secure, and stable housing and the provision of ongoing case management.

Recommendation 17

6.54 The committee recommends that the Department of Veterans' Affairs work together with the Department of Human Services and RSL Lifecare to develop a program to address veteran homelessness based on the Homes for Heroes 'housing first approach' and focus on ongoing psychosocial support.

Senator Alex Gallacher
Chair

Senator Chris Back
Deputy Chair

Additional Comments from the Australian Greens

1.1 The Australian Greens support the vast majority of recommendations in the Chair's report. The Chair's report provides a valuable chronicle of the range and gravity of issues that the committee heard of during this inquiry. In providing these additional comments, the Australian Greens are seeking to build upon the recommendations included in the Chair's report.

1.2 The Australian Greens would also like to thank those who made submissions to the inquiry and participated in public hearings, particularly those veterans who were open about their experience with mental health problems. Being able to speak publicly about mental health requires courage and strength in any setting, let alone for veterans for whom the myth and expectation of infallibility can make it all the more difficult to be open about their state of mind. The Australian Greens hope that this inquiry and the committee report is another step towards ensuring that those suffering mental ill-health, including PTSD, are treated with the seriousness and respect they deserve, both within the defence establishment and in the civilian world.

Identification and disclosure of mental ill-health

1.3 Identifying the prevalence of mental ill-health amongst veterans was the primary reference for this inquiry. Understanding the extent of the problem is central to government being able to provide proper assistance to veterans who are struggling with mental ill-health and associated problems such as homelessness.

1.4 The inquiry confirmed that there is a disparity between the figures provided by Defence and DVA regarding the prevalence of mental ill-health and associated problems, and the anecdotal evidence collected by veterans' advocacy and welfare groups. This reflects the difference in when and how Defence and DVA engage with veterans, and when and how veterans groups discuss these issues. By their nature, veterans' groups talk to veterans in more informal settings and, often, many years after terms of service. This allows for better detection of mental health problems that might be hidden or overlooked in formal settings; or that might arise many years after service.

1.5 The Australian Greens strongly support Recommendation 2 for the National Audit Office to fully investigate the scope and accuracy of record keeping regarding veterans' mental health. It is essential that the knowledge gap of Defence and DVA is properly understood and that any changes required are made to their data collection methods so that the most accurate picture of veterans' mental health be made available.

1.6 However, the Australian Greens believe that the committee report should have gone further in requiring Defence and DVA to provide an annual report to parliament so that the opportunity is provided for this issue to be tracked and interrogated each and every year.

Recommendation 1

1.7 That Defence and DVA report annually to the parliament on the ‘state of mental health’ of current and former ADF members including data on the rates of mental ill-health, homelessness, incarceration, suicidality, neurological conditions and any other issues or indicators relevant to instances of mental ill-health amongst defence personnel.

Mental health services

1.8 The inquiry heard disturbing evidence from veterans regarding the administration of the anti-malarial drug to ADF personnel. Allegations were made regarding the unethical administration of mefloquine to ADF personnel, particularly during ADF operations in Timor Leste.

1.9 Defence sought to allay the fears of veterans in a public statement issued on 30 November 2015. However, this public statement only provides figures about the rate of administration in the last five years, and obfuscates the issue of administration to veterans in Timor Leste. The public statement also fails to rule out that mefloquine was ever administered at levels above that now recommended by the Therapeutic Goods Administration; or that mefloquine was ever administered without the fully informed consent of ADF personnel.

1.10 The unanswered questions regarding the administration of mefloquine warrant further investigation. That similar issues have arisen regarding the administration of mefloquine to veterans of Australian allies gives further weight to the need for the issue to be further examined. The Australian Greens support the recommendation for the report of the Inspector General of the ADF to be published. However, without knowing the scope of the inquiry by the Inspector General, the Australian Greens feel compelled to clarify the extent of information that should be made public by Defence.

Recommendation 2

1.11 That Defence provide a full report to the committee on the administration of mefloquine and related anti-malarial drugs to ADF members, including the number of ADF members administered these drugs, their consent to this administration, and the dosage administered.

Recommendation 3

1.12 That, pending the report to the committee by Defence, the matter of administration of mefloquine and related anti-malarial drugs to ADF members is the subject of further inquiry by the committee.

1.13 The inquiry heard evidence on the emerging concept of moral injury, which refers to feelings of grief, shame and regret that might result from things seen or done during war. Moral injury seeks to describe the psychological, spiritual and cultural disconnect that veterans might have upon returning home. It is about reconciling that which happened in battle with that which is allowed in the civilian world.

1.14 This is not a new phenomenon. Stories abound of veterans who don't want talk about their war service because of how removed it is from the world they now inhabit. The potential benefit of formally acknowledging moral injury is that it

legitimises this experience, and, in turn, allows veterans to more openly discuss the difficulties they are having.

1.15 It should be made clear that while moral injury has been associated with chaplains, it is not inherently a matter of faith, and that the emerging study of moral injury is predominately clinical.

Recommendation 4

1.16 That Defence and DVA formally recognise moral injury, and develop a program to help identify and treat veterans suffering from moral injury.

Barriers to accessing mental health services

1.17 As is alluded to in the Chair's report, the barriers to accessing health services are legendary amongst veterans for all the wrong reasons. Claims processes are labyrinthine, assessment is often circuitous, and the underlying legislation is impenetrable to the layperson. Many veterans stumble at the first hurdle because they simply can't understand how to navigate the system. Although beyond the scope of this inquiry, an overhaul of veterans' legislation to make claims and appeals more legible and equitable is long overdue.

1.18 In the absence of simpler and fairer processes, veterans need assistance to navigate the system. Currently, DVA appears to be unable to provide the assistance necessary for all veterans to be able to identify and access the benefits that they are entitled to. Instead, veterans often rely on volunteer lay advocates.

1.19 The Australian Greens believe that every veteran should be appointed a paid liaison officer to provide them ongoing assistance in navigating access to mental health and other related services, including access to housing. DVA's Client Liaison Unit operates on a similar model, but is currently only available to those most in need.

1.20 Opportunity should be provided for veterans' groups, and lay volunteer advocates working for them, to provide these liaison services.

1.21 While a dedicated liaison officer would come at an additional cost to the federal budget, it would also provide an incentive for government and DVA to improve the legibility of their claim processes.

Recommendation 5

1.22 That all former ADF personnel be assigned a liaison officer to provide a single point of contact to assist in identifying needs, and navigating the range of services available and associated processes.

1.23 It is difficult to escape the conclusion that the system as it is currently operates is, in part, a result of budgetary constraints. Analysis done by the Parliamentary Library for the Australian Greens shows that, in real terms, expenditure by DVA on veterans' support services and payment outcomes has fallen more than 20 per cent in the last five years; and is now at the lowest level it has been since the turn of the century.

Recommendation 6

1.24 That funding for mental health support services for current and former ADF members are provided on the basis of need and not be subject to any arbitrary budget cap.

Discharge, transition to civilian life, and veteran homelessness

1.25 As noted earlier, the committee heard conflicting evidence from DVA and veterans' groups on the extent of homelessness among veterans. Irrespective, that any veteran gets to the point where they don't have regular shelter is an indicator that the system is failing to either identify or properly assist veterans with the most basic of needs. Geoff Evans, from Homes for Heroes, makes the salient point that all veterans that that program identifies as being homeless are suffering some form of mental ill-health, and that this ill-health has often progressed further that it would have had assistance been rendered earlier.

1.26 The Australian Greens believe that there needs to be an immediate injection of funding into programs addressing homelessness, such as Homes for Heroes. The Australian Greens also believe that the committee should further inquire into how such programs are able to be sustainably funded, with a particular emphasis on the RSL and other veterans' groups' capacity to call upon their reserves to provide further support for these programs.

Recommendation 7

1.27 That the government provide an immediate injection of funding to Homes for Heroes so that the program can properly meet the needs of all homeless veterans.

Recommendation 8

1.28 That the matter of funding by the RSL and other veterans' groups to veterans mental health and homelessness services is the subject of further inquiry by the committee.

Senator Peter Whish-Wilson

Appendix 1

Submissions

- 1 Mr Timothy Chesterfield
- 2 Vietnam Veterans Federation of Australia
- 2.1 Supplementary to Submission 2
- 2.2 Supplementary to Submission 2
- 3 Wide Bay Burnett District, Returned and Services League
- 3.1 Supplementary to Submission 3
- 3.2 Confidential
- 4 Veterans Care Association Inc
- 5 Dr Jerome Gelb
- 6 Mr Douglas Steley
- 7 Stand Tall for PTS
- 8 Name Withheld
- 9 Mr Dennis R Lee
- 10 Mr Mark Keynes
- 11 Mr Roy Seal
- 12 Mrs Margaret Cooper
- 13 Name Withheld
- 14 Mr Barry Andrew
- 15 Inspector General of the Australian Defence Force
- 16 Mr Robert Shortridge
- 17 Australian Counselling Association
- 18 Walking Wounded Ltd
- 19 The Returned & Services League of Australia

- 20 Mr Brian McCarthy
- 20.1 Supplementary to Submission 20
- 21 Mr Robert Shearman
- 22 Australian Psychological Society
- 23 Psychotherapy & Counselling Federation of Australia
- 24 Dr Annabel McGuire, Gripfast Consulting Pty Ltd
- 25 Mr Jeremy Davey
- 26 Australian Families of the Military Research and Support Foundation Ltd
- 27 Dr Kieran Tranter
- 28 War Widows' Guild of Australia Inc.
- 29 Soldier On
- 30 Phoenix Australia - Centre for Posttraumatic Mental Health
- 31 Mr Jayden Mosley
- 32 Mr Donald Sullivan
- 33 Mr Geoff Bolwell
- 34 Department of Defence
- 35 Department of Veterans' Affairs
- 35.1 Supplementary to Submission 35
- 36 Name Withheld
- 37 Confidential
- 38 Aspen Medical
- 39 Legacy Australia
- 40 Alliance of Defence Service Organisations
- 41 beyondblue
- 42 The Partners of Veterans Association of Australia Inc.

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- 43 Name Withheld
 - 44 Name Withheld
 - 45 Name Withheld
 - 46 The Royal Australian Regiment Corporation
 - 47 Veterans Federation
 - 48 Miss Alanna Power
 - 49 The Royal Australian and New Zealand College of Psychiatrists
 - 50 Dr Niall McLaren
 - 50.1 Supplementary to Submission 50
 - 51 Slater and Gordon Lawyers
 - 52 Mr John Skewes
 - 53 Department of Social Services
 - 54 Major Stuart McCarthy
 - 54.1 Supplementary to Submission 54
 - 54.2 Supplementary to Submission 54
 - 55 Veterans Health Advisory Council (South Australia)
 - 56 Name Withheld
 - 57 Name Withheld
 - 58 Mr John Lawler
 - 59 Royal Australian Armoured Corps Corporation
 - 60 Mr Dennis Crouch
 - 61 Mr Greg Hogan
 - 62 Young and Well CRC
 - 63 Mrs Christine Perry
 - 64 Dr Kevin Kraushaar

- 64.1 Supplementary to Submission 64
- 65 Confidential
- 66 Mrs Catherine Lawler
- 67 Name Withheld
- 68 Mr Derek Sheppard
- 69 Mr Dennis Bass
- 69.1 Supplementary to Submission 69
- 70 Name Withheld
- 71 KCI Lawyers
- 71.1 Supplementary to Submission 71
- 72 Mr Phil Hay
- 73 Dr Jane Quinn
- 74 Confidential
- 75 Vietnam Veterans Association of Australia
- 76 Australian Medical Association
- 77 Australian Association of Social Workers
- 78 Australian Peacekeeper & Peacemaker Veterans' Association
- 79 Name Withheld
- 80 Confidential
- 81 Dr Doug McKenzie
- 82 Name Withheld

Appendix 2

Tabled documents, answers to questions on notice, and additional information

Tabled documents

1. J Medbury, 'Post-operational debriefing in the Australian Army', *Australian Army Journal*, tabled by Mr Noel McLaughlin, Public Hearing 31 August 2015, Canberra
2. Opening statement, tabled by Mr Noel McLaughlin, Public Hearing 31 August 2015, Canberra
3. Opening statement, tabled by Dr Michael Barry, Public Hearing 31 August 2015, Canberra
4. Moral injury, tabled by Professor Tom Frame, Public Hearing 31 August 2015, Canberra
5. Opening statement tabled by Mr Brian Briggs, Public Hearing 1 September 2015, Brisbane
6. Assessment and Diagnosis of PTSD, tabled by Dr Niall McLaren, Public Hearing 1 September 2015, Brisbane
7. Opening statement, tabled by Department of Defence, Public Hearing 21 September 2015, Canberra

Additional information

1. ANAO Report No.9 (2102–2013) 'Delivery of Bereavement and Family Support Services through the Defence Community Organisation', provided by AFOM (Submission 26)
2. R Mclaughlin, L Neilsen and M Waller, 'An Evaluation of the Effect of Military Service on Mortality: Quantifying the Health Soldier Effect', *Annals of Epidemiology*, provided by AFOM (Submission 26)
3. M Waller and A McGuire, 'Changes over time in the "healthy soldier effect"', *Population Health Metrics*, provided by AFOM (Submission 26)
4. Joint Standing Committee on Foreign Affairs, Defence and Trade, 'Mental health Concerns' *Care of ADF Personnel Wounded and Injured on Operations, June 2013*, provided by AFOM (Submission 26)

5. R Newhouse and B Spring, 'Interdisciplinary Evidence-based Practice: Moving from Silos to Synergy', *Nursing Outlook*, provided by AFOM (Submission 26)
6. Department of Veteran's Affairs 'Veteran Mental Health Strategy: a ten year framework 2013-2023,' provided by AFOM (Submission 26)
7. B O'Toole, T Orreal-Scarborough, D Johnston, S Catts and S Outram, 'Suicidality in Australian Vietnam veterans and their partners', *Journal of Psychiatric Research*, provided by AFOM (Submission 26)
8. P Devenish-Meares, 'Call to Compassionate Self-Care: Introducing self-compassion into the Workplace Treatment Process.' *Journal of Spirituality in Mental Health*, provided by Rev Peter Devenish-Meares
9. *Australian Defence Force Journal*, No. 196, 2015, provided by Rev Peter Devenish-Meares
10. L Carey et al, 'Moral Injury: A systematic literature and resource bibliography for the Australian Defence Force Chaplaincy Branch,' provided by Prof. Tom Frame
11. W Kinghorn, 'Combat Trauma and Moral Fragmentation: a theological account of moral injury', *Journal of the Society of Christian Ethics*, provided by Prof. Tom Frame
12. D Brooks, 'The Moral Injury,' *New York Times*, 17 February 2015, provided by Prof Tom Frame
13. A Nazarov et al, 'Role of morality in the experience of guilt and shame within the armed forces,' *Acta Psychiatrica Scandinavica*, provided by Prof Tom Frame
14. T Frame, 'Introduction' Moral Injury: Unseen wounds in an age of Barbarism, provided by Prof Tom Frame
15. T Frame, 'Postscript Moral Inquiry: Unseen wounds in an age of Barbarism, provided by Prof Tom Frame

Answer to Question on Notice

1. Department of Veterans' Affairs – Answers to questions on notice from public hearing held on 21 September 2015 (received 13 November 2015)
2. Department of Defence – Answers to questions on notice from public hearing held on 21 September 2015 (received 23 November 2015)
3. Department of Defence – Answers to questions on notice from public hearing held on 21 September 2015 (received 1 December 2015)

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4. Department of Defence – Answers to written questions on notice (received 12 February 2016)

Appendix 3

Public hearings and witnesses

Monday 31 August 2015

The Returned & Services League of Australia

RADM Kenneth Doolan RAN (Rtd), National President

Alliance of Defence services Organisations

COL David Jamison AM (Rtd), National Spokesperson

Royal Australian Armoured Corps Corporation

Mr Noel McLaughlin OAM, Chairman

Soldier On

Mr John Bale, Chief Executive Officer and Co-founder

Australian Families of the Military Research and Support Foundation Ltd

Mrs Gail MacDonell, Executive Director

Mr Robert MacDonald, Deputy Executive Director

Mrs Emma MacDonald, Director

Phoenix Australia – Centre for Posttraumatic Mental Health

Professor David Forbes, Director

Dr Andrea Phelps, Deputy Director

beyondblue

Dr Stephen Carbone, Policy, Research and Evaluation Leader

Mr Nick Arvantis, Head of Workplace Research and Resources

Australian Psychological Society

Dr Michael Barry, Secretary, ACT Section

Psychotherapy and Counselling Federation of Australia

Ms Maria Brett, Chief Executive Officer

Professor Tom Frame

Miss Alanna Power

Tuesday 1 September 2015

Walking Wounded Ltd

Mr Bradley Skinner, Executive Officer

Stand Tall for PTS

Mr Tony Dell, Founder

Slater and Gordon Lawyers

Mr Brian Briggs, Practice Group Leader, Military Compensation

Dr Annabel McGuire

Dr Niall McLaren

Mr Matthew McKeever

Mr Ciaran Hemmings

Mr Brian McCarthy

Mrs Lee McCarthy

Major Stuart McCarthy

Dr Jane Casperson-Quinn

Mr Robert Shortridge

SOLAS

Ms Catherine O'Toole, Chief Executive Officer

Monday 21 September 2015

Department of Defence

ACM Mark Binskin AC, Chief of the Defence Force

VADM Ray Griggs AO CSC, Vice Chief of the Defence Force

RADM Robyn Walker AM, Commander Joint Health

Mr David Morton, Director General Mental Health Psychology and Rehabilitation

AVM Anthony Needham, Head People Capability

AIRMSHL Leo Davies, Chief of Air Force

LTGEN Angus Campbell, Chief of Army

RADM Michael Balen AO RAN, Deputy Chief of Navy

Department of Veterans' Affairs

Mr Shane Carmody, Chief Operating Officer

Ms Lisa Foreman, First Assistant Secretary, Rehabilitation and Support

Ms Sue Campion, First Assistant Secretary, Health and Community Services Division

Ms Veronica Hancock, Assistant Secretary, Mental and Social Health Branch

Mr Neil Bayles, Assistant Secretary, Rehabilitation, Case Escalation and MRCA Review

Ms Loretta Poerio, Acting National Manager, Veterans and Veterans Families Counselling Service

Dr Stephanie Hodson, Mental Health Advisor

Inspector General of the Australian Defence Force

BRIG James Gaynor, Acting Inspector General of the Australian Defence Force

Wednesday 18 November 2015

RSL Lifecare – Homes for Heroes

Mr Geoff Evans, Director, Homes for Heroes

Mr Ron Thompson, Chief Executive Officer, RSL Lifecare

Mr Adrian Talbot, Manager, Homes for Heroes

RSL Lifecare – Homes for Heroes – Residents

Mr Lee Sarich

Mr Gary Norman

Mr Thomas Pulleine

The Royal Australian Regiment Corporation

Mr Michael von Berg, Chairman and President

KCI Lawyers

Mr Greg Isolani, Partner

The William Kibby VC Men's Shed

Mr Barry Heffernan, Shed Coordinator