Inquiry into transition from the Australian Defence Force (ADF)

12 July 2018

Committee Secretary
Joint Standing Committee on Foreign Affairs, Defence and Trade
PO Box 6021
Parliament House
Canberra ACT 2600

Dear Committee Secretary

Thank you for providing the opportunity to make a submission to The Committee examining the very important issue of support provided to members of the Australian Defence Force (ADF) as they transition from active service to civilian life. This period, understood in the international literature as military to civilian transition (MCT), is critical to the long-term occupational, health, and mental health trajectories of our service personnel and veterans.

This submission is made by Dr Paula Dabovich, Adjunct Senior Lecturer, School of Public Health, The University of Adelaide, who has a background that includes health care and military service (as a General Service Officer). She completed her PhD in April 2018, and examined the experiences of service personnel undergoing rehabilitation and MCT in the Australian Army. This research, conducted over four years, provides insight as to how and why many military personnel experience physical, psychological, and social decline during MCT. It also documents the ways in which some veterans were able to adapt to these changes, and why others had difficulty doing so. These insights have become increasingly critical in the light of two reports recently released by the Departments of Defence and Veterans' Affairs (DDVA). These reports demonstrate almost 50% of those in MCT become psychologically symptomatic of disorder (Van Hooff, Lawrence-Wood, Hodson et.al, 2018), yet only 25% of those who are unwell were engaged in evidence-based care that might otherwise improve their long-term health and occupational outcomes (Forbes, Van Hooff, Lawrence-Wood, et.al., 2018).

This submission first provides a brief summary of what we know about MCT from an international perspective. It then addresses the areas of concern to the committee, and finally recommendations are made as to how our nation can better support veterans during MCT.

The international perspective

The observation that veterans often do poorly in and around MCT is recognised in Australia and abroad. Because of this shared observation, an extensive review of the academic literature was conducted by the Canadian Institute for Military and Veteran Health Research (Shields et al., 2016), in which 306 articles from Australia, the US, Canada, and the UK, were annotated and synthesized. Some articles provided conceptual models of transition linkages to mental health disorders, general health, suicide, and difficulties with healthcare engagement, yet because these were described in terms stemming from various fields (mainly within the social sciences), the authors noted that the evidence was fragmented and uncoordinated. Moreover, it was suggested the models simply described the events of transition rather than attempting to understand them in a way that could yield practical and positive change (Shields et.al., 2016). Indeed, the accumulation of evidence does not appear to be linked to an acknowledged international framework or program of research that

can systematically advance knowledge of MCT, upon which support services and interventions can be critically analysed, prioritised, or audited.

A plausible explanation of this lack of coordination is the notable absence of transition theory in the field of military medicine. Currently, as an academic discipline, military medicine has only two interests. The first relates to preventative interventions that help maintain the health of military personnel, and the second relates to clinical interventions that help return the wounded, injured, and ill to duty (Craig, 2014). As yet, an internationally recognised and medically-framed biopsychosocial model of MCT that accounts for the intrapsychic processes of the individual during change, and further relates these to health and mental health outcomes is not established. It is only through such an account that the work stemming from various fields, such as physiology, sociology, psychology, and anthropology, can be conceptualised and synthesized in a way that can be usefully translated across academic and clinical fields, as well as community support systems. Adopting a holistic medical model of this type is important in the field of MCT, because many of those who develop psychological disorders or engage in suicidality during or after transition from the military, are often discharged on medical grounds (Australian Institute of Health and Welfare, 2017; Van Hooff, Lawrence-Wood, Hodson et.al, 2018). For these veterans, the health system is experienced as the conduit from the military to civil society and as such, it may also be understood as a system that facilitates (or could facilitate) transition. Because of the strong relationship between veteran health, the health system, and transition, every opportunity must be harnessed to maximise synergy between them.

The aforementioned PhD dissertation provides a biopsychosocial medical model that accounts for the individual over time. Although the results of this study are not directly referenced in this submission (in accord with Defence protocol), insights gained from it are used to address the issues of interest to the committee.

Issues of interest as outlined by the Committee

The barriers that prevent ESOs from effectively engaging with ADF members, the Department of Defence and Department of Veterans' Affairs, to provide more effective support to ADF Personnel as they transition out of service.

There is a lack of shared understanding of the crisis facing the system for veterans, due to a failure to comprehend and account for the loss of selfhood experienced by those transitioning out, particularly on medical grounds. This lack of shared understanding stems from the absence of a recognised overarching framework that accounts for selfhood, and through which shared concepts and language may be usefully recognised and employed. Without an agreed-upon framework to facilitate these linkages, there will be little opportunity to shape services (and organisational roles) in a way that honours the need of the veteran (as represented by them as individuals and through ESOs), and yet appeals to the organisational priorities of the military and DVA. Indeed, one of the core recommendations stemming from the literature review of Shields et al., (2016) (also described above), was to create a taxonomy of language that could promote an understanding of MCT across international borders, organisations, and academic fields—all of which inform clinical and transition services that may otherwise help veterans navigate their post-service lives.

In addition to the above, intermediary strengths-based rehabilitation and transition nodes are critical to MCT, both within the military and civil community that are further grounded in public health principles. A good example of a successful process of rehabilitation and transition is provided by the 1st Brigade Soldier Recovery Centre-Adelaide (SRC-A). This enables those who are undergoing rehabilitation to return to their unit with a greater sense of maturity and complexity, or transition to

civil society with a strong foundation and dignity. SRC-A utilises service members who have undergone and overcome the challenges of rehabilitation within the military, who are respected amongst their peers and thereby represent shared strengths of those facing similar challenges (by way of shared service history) and shared vulnerabilities (by way of adapting to the challenges of reduced function). Because of these shared strengths and vulnerabilities, SRC-A has successfully developed strong relationships with units within the military, and organisations outside of it. Of the latter, SRC-A has developed strong relationship with central veteran community nodes such as the State funded Partnerships Hub which aims to provide veterans with a united service bringing together local, State, and Commonwealth agencies, including ESOs and DVA. The Partnerships Hub is also run by a veteran who also has shared strengths and vulnerabilities, as they relate to transition. From a developmental theoretical perspective, these nodes (SRC-A and Partnerships Hub) and those who manage them, represent *transitional objects*—that is, spaces and people where and with whom regression and redevelopment of identity may safely occur, and around which new ideas of selfhood may be conceptualised and achieved.

Improvements of treatment outcomes.

The ability of a soldier to transition effectively not only rests on the ESO's ability to engage with DVA and Defence (as addressed above), it also relies on the ability and willingness *of the ADF member* to engage with these organisations. What the ADF and DVA may need to more fully consider, are the ways in which service necessarily impacts an individual's ability to relate to (and thereby trust and tolerate) those outside the ADF, and how this impacts on an individual's relationship with themselves. A lack of trust in, or tolerance of, self and others, impinges on an individual's personal sense of identity and agency (sense of self) during MCT, which in turn, impacts an individual's willingness to engage support services and tolerate many ambiguities associated with them.

There are several ways to facilitate MCT experiences that account for the individual (issues of cognitive and physical function) and their relationship with others (issues of connection, trust, belonging, and emotion). This may ultimately promote relationship with ESOs, DVA, and other services that help shape veteran health and occupational trajectories. For example, veterans can be supported in redeveloping identity, and thereby relationships and tolerance, through augmenting therapeutic approaches currently used to treat disorder during transition. Such therapies endorsed by Defence and DVA are primarily cognitive, behavioural, generalised, manualised (i.e. they can be applied to anyone), and focus on the correction of thoughts and behaviours. In short, these approaches treat symptoms more than cause and in doing so, do not consider temporal aspects of individuals, each of whom has a unique past (which includes the military) and a unique future to forge. This is not to imply that current therapeutic interventions are not useful—they are. They are simply not the whole answer because they do not consider the aetiology of disorder and this is critical to achieving effective long-term health outcomes for the individual, or for public health more broadly.

Individual development is key to conceptualising the challenges of MCT, because the very nature of military service alters the course of it, relative to most civilians. This alteration is highly adaptive and necessary to capability (common values serve to bind the collective, who depend on one another for survival to achieve significant and often dangerous tasks on behalf of Australia and its people). However it may become problematic when adaptation to civilian life is called for. An individual sense of self is understood as the culmination of a personal identity and sense of agency, providing a platform that helps an individual tolerate ambiguity and sustain healthy relationships (American Psychiatric Association, 2013). In an MCT context the sense of self developed in service (that is more collective and mutual) may be considered as an antecedent to the tension and symptoms

experienced during transition when a service member is required to operate in a society which is largely individualistic (Hajjar, 2014). Such tensions can present as symptoms of disorder, which are currently treated post hoc, rather than addressed directly. This oversight may be why cognitive, behavioural, generalised, and manualised treatments have high attrition and low efficacy rates in veterans, relative to those in the civil community (Steenkamp, Litz, Hoge, & Marmar, 2015) and why many seek care, yet do not stay engaged long enough to significantly benefit (Forbes, Van Hooff, Lawrence-Wood, et.al., 2018).

To improve engagement in clinical care, as well as ESO and DVA services (as highlighted by this inquiry) there are existing therapeutic modalities which may have utility in the veteran community during MCT, all of which address and support individual identity (including issues of self-awareness, purpose, and meaning) and thereby, the ability to tolerate and engage with others, including organisations such as DVA and ESOs. These include existential approaches such as Narrative and logotherapy, along with psychodynamic therapy. Interestingly, theories that support these approaches stem from theorists who were themselves, medical officers, and almost all of whom had also served in the military or experienced the horrors of war, first hand. Nonetheless, these approaches may not fully address the needs of those transitioning from service in the current Australian context, but they would serve as excellent additions to the therapies currently endorsed. The disjuncture between what therapeutic interventions veterans may need and what is currently endorsed is reflected though the high rates of disorder in the MCT population, and the low rates of therapeutic engagement, which is perhaps reflective of the lens through which MCT is currently viewed by Defence and DVA. It also highlights the requirement to further research and frame what veterans need during MCT, as well as what they are offered, what is developed, and further, the capacity to critically analyse these.

The model of mental health care while in ADF service and through the transition period to DVA; The responsiveness of Defence and DVA to emerging international knowledge in the care of Veterans and the advice of health professionals.

Critical analysis of support systems and therapeutic interventions against a disciplined framework during transition may also go some way to highlight limitations in current MCT and mental health care, as it occurs between the ADF, DVA, and the civil community. It also highlights the problems that arise when organisations work within a perspective, here, one that does not account for insight gained through emerging international knowledge in the care of veterans (which is becoming increasingly recognised as a public health issue), and the advice of health professionals who work with them.

For example, a phrase widely used in and around veteran health in Australia is that of *veteran centric care,* or in the case of DVA, veteran centric *reform* (2016, 2017). In the MCT context, the term "veteran centric" needs careful consideration. In the current purchaser-provider model employed by DVA, that which distinguishes a person who has served from those who have not served is the funding stream and administrative service used to account for health services for conditions that have been accepted by DVA, or for non-liability mental health care. Whilst the DVA's veteran centric reform's (2017) primary aim of streamlining administration and communication to enable better access to services is commendable (and will undoubtedly result in improved access to care when veterans need it), the services themselves do not account for the ways that the military shapes an individual, and how this may impact on health and health behaviours. Again, this oversight is reflected in the rates of veterans seeking help for psychological distress (i.e. high rates of presenting to a health professional) yet low rates of engagement in care (Forbes, Van Hooff, Lawrence-Wood,

et.al., 2018). This pattern is concerning given the high levels of mental health disorder and suicidality in the MCT population (Van Hooff, Lawrence-Wood, Hodson et.al, 2018).

A public health perspective of the term "veteran centric" would account for a person's culture of origin, around which they have become psychologically organised, and the ways such organisation shapes health and health behaviour. More so, it would account for the ways their culture interfaces with the dominant civil culture and incorporate this understanding in designing and delivering the care (i.e. it would build on what they know and value), thus improving retention rates and health outcomes.

In addition to the above, the research proposed by DVA's veteran centric reform appears to be based on tracking data related to *what, when, where, and how* health services are used, but does not account for *why* it happens or does not (DVA, 2017). Although tracking patterns of service utilisation will be helpful to create budget forecasts, without the insight as to why these patterns occur little can be done to shape services that may otherwise help curtail health decline and chronicity—the cost of which is ultimately underwritten by the Commonwealth of Australia. A more useful approach may be to view these statistics through the lens of a well-grounded overarching framework which will help communities, states and the Commonwealth comprehend patterns of healthcare utilisation, and thereby better support the individual veteran achieve optimal health outcomes.

The need to adopt such an approach may be observed in considering the chronic health outcomes of Vietnam era veterans, some 30 years after the Vietnam War. Of 67 recognised chronic health conditions, 47 were higher in these veterans compared to community expectations, and only four conditions were lower (Brian, O'Toole, Catts, et.al., 2009). If this level of chronicity is to hold true for contemporary cohorts—and the transition data suggests many are not doing well and the cohort is exceeding lifetime prevalence rates for some mental health disorders—the consequences of a purchaser-provider model that is not framed and therefore doesn't account for the impact of military service on the individual, may have serious fiscal consequences.

The efficacy of whole of government support to facilitate the effective transition to employment in civilian life of men and women who have served in the ADF.

There are two ways of understanding a community. The first, is a *community of interest* which is connected through mutual culture, activity or concern. In this instance, it does not matter where an Australian veteran lives or works, they hold connection to other veterans through their service history and potentially through ESO engagement. The other way of understanding community is through *community of place* which represents the connection a person has to a place, or others in that place, such as an area of residence. This distinction is critical in understanding veteran employment and community pathways because an optimal sense of belonging may be found when a community of interest is met with community of place. To that end, there may be some utility in hypothesizing the role of each sector of Government in helping veterans find themselves occupationally and socially, through each of these layers of community.

In relation to a veteran's community of place (during transition and after service), there seems to be little dialogue regarding the role (and potential) of local councils in identifying and engaging its veterans to acknowledge their service and potentially draw on it. This oversight begs the question: how does a local community engage or employ its veterans (in a paid or voluntary capacity) if they don't know who they are? One such way to mitigate this problem might be to engage council and local RSLs to acknowledge their veterans (and respectfully introduce or re-introduce them) during or after Anzac and Remembrance Day services. Connecting veterans to their community of place (or

more importantly having a community place connect to them) in this somewhat symbolic and intimate way (which is far from the anonymous mass of a parade), may help veterans embrace their identity of interest with their identity of place, and open informal pathways of employment and volunteer opportunities.

At a national level, the Commonwealth unites people through a community of interest when it recruits members of the military and should therefore take ownership of supporting veterans through transition, as they experiment with new interests and occupation. As has been suggested elsewhere, this may involve a Commonwealth supported 12-month veteran internship across multiple industries or governmental departments. Ideally this might involve three to four rotations between different departments of a nominated industry, over 12 months. This would give veterans the opportunity to learn new skills, industry language, and to build relationships with others. Given that transition is a period of both decline and growth, such an internship would be ideally allow for mistakes to be made without judgment (because people often find out *who they are*, through first finding out *who they are not*) and provide opportunities for creativity.

Nested between local council support of the veteran and that of the nation, is State governance. The State has a vested interest in the health and wellbeing of veterans, especially through the transition period, because if this process is improved, there may be positive long-term fiscal implications for Health, Corrections, and other state-based social services. Because of this, States may hold a pivotal role in coordinating and providing oversight to veteran services, during transition and after it. Such coordination and oversight may include engagement with, and providing synthesis between local and commonwealth agencies, local industry (for employment), military and veteran health services, along with ESOs and DVA. Because the State sits at this important juncture of representation and coordination, the States should continue to hold voice at a national level, through initiatives such as the Veterans Ministers Round Table and the Commonwealth, State, and Territory Veterans' Committee.

The optimal structure and range of services that could be provided by a national network of clinics for ADF members and Veterans were a different approach adopted.

The MCT experience is currently dominated and defined by the following:

- fragmented services between Defence, DVA, ESO's and the civil community;
- medical and psychological interventions that don't account for relationships forged in service, and the impact these have on a veterans health and health behaviours; and
- high levels of disorder and low levels of retention in treatment services.

Although there is much work to be done by the international academic and clinical communities to develop a robust model against which innovative treatments and services may be advanced and critically analysed, a simple short-term model may be grounded in public health and developmental theory (Dabovich, 2018). Such a model situates MCT as an opportunity for growth, whilst simultaneously accounting for the levels of disorder and distress in what is clearly a vulnerable population, albeit one that holds much potential to enrich civil society. Ideas of optimal strategic and more immediate service provision, are outlined in the recommendations below. These recommendations are based on three elements that are known to support and individual through change: drawing out self-structures through identity (i.e. who I am by way of unique and shared values); agency (i.e. who I am by way of what I do such as may be experienced through occupation, recreation and volunteering); and through creating and upholding a military to civil facilitating framework that support these processes of selfhood.

Facilitating selfhood

Research. There is a significant need to coordinate of a more unified research effort that can build upon the existing strong body of work in a way that enables translation to practical support systems and clinical care during the sensitive period of MCT. Without such coordination, efforts appear to be largely driven by the interests, initiative, and resources of independent departments and research bodies (Shields et al. 2016, p. 135), which precludes advancements that may otherwise improve outcomes for our veterans.

Shields et al. (2016) further recommended coordination of language and priorities, formalised and regular opportunities for international dialogue, an agreed upon taxonomy for organising language and literature, and an agreed upon conceptual framework for approaching military to civilian transitions. Such ambition clearly requires an overarching theory that can account for the biopsychosocial elements of self, as it exists in changing occupational, social and functional contexts, over time.

To build on and develop the guidance provided above, a research program that would enable further inquiry would be highly beneficial, seeing Australia as leading the development of a theoretically framed military to civilian transition program—one facilitates the best possible health outcomes for veterans. With this knowledge, it will be possible to determine the feasibility and benefits of creating targeted intervention programs utilising the theoretical insights gained previously, programs that will resonate with and better meet the needs of military personnel and veterans as they transition out of service. To pursue this program of research and further build upon the strengths of previous research (Dabovich, 2018) which is acknowledged by many as representing new findings and an innovative, world-first approach to the challenges faced, a collaboration between the ADF and DVA, with support from the Government of South Australia is proposed. Ideally this study would involve robust collaboration with the UK, USA, NZ, Canada and other interested nations. Such collaboration will help to develop an internationally agreed upon taxonomy and framework, upon which clinical, community, and transition services may be modelled, critically analysed, and audited.

Clinical services. Whilst there is substantial commitment from DVA in streamlining their administrative services, under the current military, DVA, and State-based healthcare systems, veterans are likely to continue to experience their healthcare as fragmented and uncoordinated. This is in part due to changing clinicians through personal posting cycles, the posting cycles of ADF clinicians, and through the need to find new clinicians during and after MCT. Building on DVA's administrative streamlining, there exists the potential to combine ADF and DVA health services into a single entity—one which can more seamlessly engage with (and help inform) state-based clinical and community services. A united military/veteran health system may help promote connection and improve the continuity of care veterans receive, especially during the vulnerable period of MCT, into a more stable and specialised clinical workforce.

A key element of this service, would be to build a network of General Practitioners and other health professionals, through the combined ADF/DVA health system described above (or through relevant colleges or organisations), who understand veteran health issues as they may occur during MCT and after it, and who are familiar with ADF to DVA healthcare administration. Such a network (which may involve the identification of practitioners and counsellors who themselves have served), would ideally be available through a database that can be accessed by military personnel and their families. Again, this service will create an intersection between a community of interest (shared service or interest in it) and community of place.

Upskilling clinicians. To help improve the health trajectories of veterans, especially as this is shaped through MCT, clinicians should be upskilled in issues of veteran health and mental health, including in the theoretical underpinning of an overarching framework as described earlier. Given the seriousness of the MCT issue, and its long-term health and fiscal implications, upskilling may involve a national education mandate that connects veteran health research and resultant theory, to training in, and application of clinical interventions.

Enhance formal links between local, state, and national government bodies. As highlighted in this submission, there is a need for an overarching system that accounts for (and helps coordinate) the multiple (and often overwhelming) stakeholders involved in veteran health and social services, especially around MCT. Because the State sits at the intersection of national and community priorities, it should continue to be supported by the Commonwealth in this leadership role, which must work closely with public and private health services to provide a unified means of respectful advocacy on behalf of the veteran community.

Who am I (identity) and what could I do (agency)?

Transition spaces. Because MCT involves decline, and yet holds potential for transformation and growth, transition services must include spaces where vulnerability can be safely achieved. These spaces should be staffed by those who are well equipped to tolerate distress and support identity development. A public health approach to this space would ideally see services in place (including therapeutic ones) that help draw out the strengths and values of those in MCT, which may be then applied in new occupational and social settings. Such spaces should exist in-service (as may be represented by some SRCs), and in the civil community (such as represented through South Australia's Partnerships Hub), involve families, and facilitated by those who have undergone similar experiences, such as peer support workers with additional training. In addition, transition spaces are those where ESOs and DVA may also engage with their target populations.

Evaluating therapies and programs that help participants draw out selfhood. There may be utility is evaluating and creating an evidence base that accounts for therapeutic interventions that draw out issues of selfhood (i.e. identity, agency, self-awareness, meaning and purpose), which ultimately helps support relationship development, during transition and after it. These interventions may include psychodynamic, narrative, or logo-therapeutic approaches, which aim to partly address causes of anxiety, depression, and other mental health conditions.

Conclusion

A veteran's sense of self is affected by service, up to and including experiences of wounding, injury, and illness, as well as rehabilitation and transition. Each of these experiences offer unique opportunities that shape and enable expression of identity, which shapes and enables the expression of agency, which further influence health behaviour and health outcomes. There is both a moral and fiscal imperative to consider the constructs of self in the delivery of veteran healthcare, with an even greater need for dialogue around veteran self-other rebalancing at critical times of change such as during MCT. The nascent framework referenced in this submission is the first of its kind globally, that offers a holistic and medically informed theoretical base that can assist in supporting a veteran's identity, and potential shifts in identity during times of change such as rehabilitation and transition. If built and managed well, a thoughtful and functioning military to civilian transition system may help society meet the needs of those who have offered so much, and in doing so, enrich our own worldview, as we learn from those who have so much to offer.

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