Submission to the National Commissioner for Defence and Veteran Suicide Prevention Bill 2020 and the National Commissioner for Defence and Veteran Suicide Prevention (Consequential Amendments) Bill 2020

Date: 8th October 2020
Submitted by: Lucas Moon (President) on behalf of Hawthorn RSL Sub-Branch

Declaration of interest:

Hawthorn RSL welcomes the recognition of the need for concerted action into the factors and systemic failures that have led to the unacceptably high rates of suicide of our mates in the Australian Defence Force (ADF) member and veteran communities.

Hawthorn RSL is the largest traditional Sub-Branch in Victoria. We are proud to represent more than 200 Service and over 40 Affiliate members, a high proportion of those being younger veterans from East Timor, Iraq the Solomons and Afghanistan. Hawthorn RSL provides accommodation, employment referrals, funeral assistance and bonds for accommodation and assistance with DVA claims.

We run solely on donations from our community of veterans and families and often use those funds bridge the gap in veterans needs in the absence of support from DVA. This means that veterans and families are in effect, funding their own support, which we believe proves a failing in the support service provision from the Australian Government.

RSL and RSL Sub-Branches should be a refuge for veterans to relax and express themselves with like-minded individuals. This is why we are proud to have approvals, a concept and costing for an upgrade of our RSL Building. This space also has the added advantage of bringing Advocates and DVA in to RSL and not the other way around.

The last 20 years have been the busiest deployment period for Australia since the Vietnam War. At its busiest, just over 2000 Australians were serving overseas at any one time. This is indicative of the disconnect between the veteran community, which numbers in the tens of thousands and the wider community of 24 million.

As a Traditional Sub-Branch who works closely with our members, some of whom have been deployed sometimes up to 11 times, we understand the short and long term issues that many veterans face and the overwhelming urgency of the issue of veteran suicide.

Consumer input:

We believe it is necessary to bring attention to the links between veteran suicide and the institutional failures and bureaucratic barriers to helping military personnel after they leave the service and to make some recommendations on actions and strategies to support the

prevention of future suicides. Military service puts unique pressure and stress on those who undertake it, and therefore requires a unique response.

On average more than one veteran is taking their own life every week and there is evidence to suggest that the number of veterans suiciding is higher than reported and that we may never understand the true number of veteran suicides[1].

As part of this submission, we call for:

1. **A complete and independent Royal Commission into Veteran Suicide Prevention including those who have attempted suicide.**

Hawthorn RSL strongly believes the Australian Government has failed our veterans. We note that while the Attorney General's Department states that "Under the Bills, the National Commissioner will have relevant powers broadly equivalent to a Commonwealth Royal Commission", the Interim Commissioner will not and therefore this is not an adequate solution. Hawthorn RSL strongly calls not for an open-ended National Commissioner, but for a complete and independent Royal Commission in to Veteran Suicide Prevention, with a specific time-frame.

Hawthorn RSL calls for inclusion of veterans who have attempted suicide as the only way to appropriately examine and support the prevention of future deaths. Veterans' Affairs data shows 986 hospitalisations for intentional self-harm from 2000 – 2016 involving 786 veterans. Section 3 of The Act states: "The object of this Act is to provide for a Commissioner to examine defence and veteran suicides, in order to support the prevention of future such deaths." To achieve this, the voices of those veterans who have attempted suicide must be heard.

2. **A full investigation into the contributing stressors associated with serving and the identification of the ADF as the root cause of veteran suicide.**

The Mental Health Prevalence and Wellbeing Study (MHPW) found that more than half of the ADF population sampled had experienced mental illness in their lifetime. This is significantly higher compared to the general population[2].

While the issue of suicide is complex, there are some critical areas of the Defence and post-Defence experience that are common contributing stressors to mental ill-health[4]. Including:

a. Occupational stressors including high exposure to traumatic events and a limited opportunity to debrief and recover whilst in the field.
b. The stoic belief and ability to keep going, no matter what results in a stigma associated with mental illness and help-seeking in the military.
c. No formal process to identify and respond to the early symptoms of mental ill-health until a breaking point is reached.
d. The process of transitioning from Defence to the civilian workforce is not prioritised highly enough. Work has long been recognised as a protective factor against suicide.
e. Increased isolation due to the lack of social support networks and lack of services for families, post-Defence.
f. The DVA compensation system is complex and slow and provides disincentives to work depending on the compensation Act the person falls under. Veterans deserve closure without having to spend years in compensation "limbo".

3. **Acknowledgement of the significant shortcomings in the provision of through-life quality care for veterans and limited support during their transition to civilian life.**

Early intervention is key in preventing suicide and treating mental disorders. Transition is currently a 'one-size-fits-all' with little to no identification of high risk ADF personnel prior to discharge and many people leave the ADF with no civilian plan in place.

Often current and ex-serving members present with multiple complex issues in the social, relational, psychological, and work domains and do not experience an easy transition to civilian life. This can lead to depressive conditions, financial distress and mental illness.

The ADF needs to identify individuals at high risk prior to discharge, provide them with non-government professional advocacy services, fast track their DVA claim(s) and provide case management support.

4. **Improved post discharge support for veterans accessing current clinical PTSD Treatments.**

Many veterans do not receive post-treatment pathway and go home to little or no social or personal support, family difficulties or a marriage/partnership under severe stress. As a result of this, veterans discharge and can immediately withdraw from their families and often turn to self-medication.

On discharge, accredited clinical treatment facilities must connect the veteran with their GP, treating psychiatrist or psychologist and give the veteran a clear pathway to clinical support post-treatment[5].

5. **A restructure of the current claims system of DVA which is inflicting ongoing damage to veterans (including causing the suicide of some) and wasting millions of dollars of government funds each year.**

The psychological stress that is put onto families to prove that their injury was as a result of their service is unacceptable. Why do we place the onus of proof on a veteran and why do we not simply give them the benefit of the doubt? Unfortunately, the culture that has developed in the DVA over time is one where the petty checking of evidence has replaced an overarching concern for the wellbeing of veterans.

DVA also adopts a piecemeal approach to support for mental illness must also look at this area more holistically. For example, DVA does not provide transport to and from psychology appointments, but they do so for psychiatric appointments. DVA must commit to providing equal access to PTSD treatments across the board.

6. **A merge of the three Acts of Parliament administered by the DVA, as this is an ineffective approach to the support and compensation of veterans in Australia.**

Attempts to improve the support provided to veterans over the years has resulted in three separate Acts of Parliament. These are the:

a. Veterans' Entitlement Act, 1986 (VEA),
b. Safety Rehabilitation and Compensation Act (SRCA), and the
c. Military Rehabilitation and Compensation Act (MRCA)[6]

The interplay between the three extant Acts administered by DVA, and their procedural interaction with ComSuper are not able to be easily understood by those they are designed to assist, particularly when they are suffering from a mental health condition.

It is common for veterans to have to lodge claims on DVA against more than one of the Acts listed above, which increases the complexity and duration of the claims process. The complexity of MRCA alone, and the extended investigations into the range of entitlements (Permanent Impairment, Incapacity and Rehabilitation) should indicate a broken system.

1. Mental Health of Australian Defence Force members and veterans (2016). Parliament of Australia. http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/ADF_Mental_Health/Report
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4138701/
3. https://www.dva.gov.au/newsroom/vetaffairs/vetaffairs-vol-36-no1-autumn-2020/national-commissioner-suicide-prevention
4. Centre for Military and Veterans' Health, The Middle East Area of Operations (MEAO) Health Study: Census Study Report, 14 December 2012, p. 68.
5. Phoenix Austrlalia (2013). Australian Guidelines for the treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. http://phoenixaustralia.org/resources/ptsd-guidelines/
6. https://www.pc.gov.au/news-media/pc-news/veterans#:~:text=The%20current%20system%20has%20three,Compensation%20Act%202004%20(MRCA).