4

A Badge of Honour

Physical injuries

4.1 Chapter Four considers the rehabilitation process of Australian Defence Force (ADF) members who receive wounds and injuries while on operations. It also addresses broader Department of Defence (Defence) health care responsibilities, and the various rehabilitation and support programs available to assist members in their recuperation.

Rehabilitation and recovery

4.2 Professor Peter Leahy AC highlighted to the Committee that:

> For most Australians, Afghanistan is a long, long way away. We acknowledge the sacrifice of those who die, but I am not sure that we know just what is happening to those who come home wounded or, indeed, those who just come home and it has been pretty tough for them.[1]

4.3 Defence advised the Committee that within five to ten days of returning to Australia, a wounded or injured member is placed in the ADF rehabilitation program to manage all their health and rehabilitation requirements. The ADF rehabilitation program aims to:

- reduce the impact of injury or illness through early clinical intervention;
- reduce any psychological effects of the injury;
- return the member to suitable work at the earliest possible time; and

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1 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 7.

- provide a professionally managed rehabilitation plan tailored to individual needs.[2]

Defence health care responsibilities

4.4 Defence submitted that whilst the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the ADF member may be posted, the Surgeon General Australian Defence Force/Commander Joint Health is responsible for the technical control of ADF health services. This includes all personnel involved in the provision of health care (which includes psychology services) within the ADF, the provision of specialist health advice, development of policy on health issues and delivery of all garrison health care.

4.5 Joint Health Command is responsible for the Defence health care system which is designed to prevent and minimise the impact of operational, environmental and occupational health threats and to treat ill, wounded and injured members. As previously noted, the provision of health care to ADF personnel does not start when an individual is wounded or injured and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation.

4.6 Components of this health care system include all routine and emergency health care within Australia, health promotion activities, pre-deployment fitness assessments, first aid and advanced first aid training for non-health personnel, operational health support in theatre, a tiered medical evacuation system and post deployment assessment and care, physical and occupational rehabilitation and mental health support.[3]

4.7 Defence submitted that Joint Health Command provides the standard of health care required in order to ensure the operational readiness of the ADF, and enable all personnel to perform their military duties. Defence has a commitment to managing the health consequences of operational service as well as providing health treatment to wounded and injured personnel.

4.8 Defence advised that Joint Health Command is required to provide to members of the Permanent Forces such health care as is deemed necessary

2 Department of Defence, *Submission 17*, p. 15.

3 Department of Defence, *Submission 17*, p. 2.

to detect, cure, remove, prevent or reduce the likelihood of disease or infirmity which affects, or is likely to affect:

- The efficiency of the member in the performance of their duties; or
- Endangers the health of any other member; or
- Assists to rehabilitate the member for civilian life; and
- Restores the member, so far as is practicable, to optimal health in the ADF context.[4]

Garrison health care

4.9 Defence's submission states that Joint Health Command is responsible for the ongoing health care of all ADF personnel when they are not operationally deployed. This includes specific health care needs such as routine health care, regular health checks, comprehensive vaccination programs, pre- and post-deployment screening, and health care to manage the physical, mental and social wellbeing of the fighting force to ensure they remain 'fit to fight'. Joint Health Command staff also maintains strong communication pathways with units and Commanders to ensure that the welfare and health needs of individuals are coordinated, comprehensive and well managed.

4.10 This suite of preventative and primary health care is delivered through five Regional Health Services across Australia. Each Regional Health Service has a number of Health Centres and Clinics which deliver healthcare and support to ADF personnel and Commanders to ensure continued operational capacity and capability of ADF personnel. Current health services delivered include primary health care, preventive health care, diagnostic testing, pharmaceutical supply, physiotherapy services, dental services, mental health and psychology services, access to specialist medical care, access to tertiary level inpatient services within the civilian local hospital/healthcare network, and rehabilitation services including specialised case management. Joint Health Command services are delivered by a wide range of practitioners including:

- Uniformed doctors, nurses, dentists, medics and allied health professionals from all three Services;
- Australian Public Service health practitioners within health centres and clinics;
- Contracted health providers who assist in the provision of many clinical roles;

4 Department of Defence, *Submission 17*, p. 2.

- Reserve health practitioners who provide clinical services and specialist care; and
- Civilian specialist health providers who provide advice and support to Joint Health Command practitioners while also providing specialist health care for ADF personnel.[5]

4.11 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health Command advised the Committee that on-base garrison health care services transitioned to the new service provider beginning in November 2012. She advised that the five service arrangements have transitioned successfully and that she was unaware of any ADF member who has not received health care for an urgent medical condition.[6]

4.12 Defence went on to advise the Committee that they are confident that:

- All garrisons have access to the required level of health services both on-base and off-base; and
- Sufficient levels of outsourced arrangements are in place to ensure that ADF personnel continue to receive timely and clinically appropriate care within their locale.[7]

4.13 Defence acknowledged that throughout the contract term there will be workforce pressures for the on-base services due to critical workforce levels in the health industry, especially in remote localities and areas of need. The current percentage of positions filled is approximately 93 per cent nationally. Defence submitted that they and Medibank Health Solutions (MHS) continue to work together to ensure sufficient fill rates for on-base personnel are achieved across the garrison environment; and that ADF personnel continue to receive timely access to high quality health care.

4.14 Defence submitted that it is confident that ADF personnel have continued to receive timely, clinically appropriate care within their locale during the transition to the new off-base services arrangements. Whilst there were initial concerns regarding the sufficiency of the off-base service provider numbers, Defence and MHS claim to have worked through these concerns to ensure appropriate access for the ADF.

4.15 Defence said that MHS continue to monitor, review and grow the off-base service provider list and will do so through the life of the contract to ensure appropriate, timely access is available to the ADF; and also ensure that it is aligned with Defence's changing healthcare needs. Defence

5 Department of Defence, *Submission 17*, p. 3.

6 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 7.

7 Department of Defence, *Submission 38*, p. 2.

advised the Committee that they will continue to work with MHS throughout the contract term to ensure ADF personnel have access to appropriate care through the off-base service provider arrangements.[8]

4.16 Defence went on to advise that they undertook a customer satisfaction survey from 1 August to 31 October 2012 which was intended to provide a baseline of customer satisfaction prior to entering into the ADF Health Service Contract. The next iteration of the survey is scheduled to commence in September 2013. The final report of the survey is still pending however the following data was provided. Of the 5,341 customers of ADF health services who provided a valid survey response about their visit:

- 82.8 per cent were seen within 30 minutes of their scheduled appointment;
- 34.6 per cent were able to get an appointment in less than one week;
- 23.4 per cent took more than three weeks to get a non-urgent medical appointment;
- 74.2 per cent agreed that access to the health service they required was available in a reasonable timeframe;
- 73.3 per cent indicated that they were satisfied or very satisfied with the health service provided; and
- 64.0 per cent agreed or strongly agreed that the overall quality of the health service they received was excellent.[9]

4.17 Mr Brian Freeman, the Director of Centori Pty Ltd, advised the Committee, however, that that 'nearly all' the hundreds of wounded and injured soldiers who have visited the Mates4Mates Family Recovery Centre say that the time it takes to get an appointment with the Defence system for treatment – 'mental, and even sometimes physical' – is too prolonged.[10]

4.18 At least one submitter felt that doctors and physiotherapists are dangerously underqualified, do not care about the injuries of soldiers, and have a total lack of professionalism.[11] There were also reports of substantial wait times:

> With the processes that we have and the waiting times for medical stuff, it was probably four to five months before I could get an MRI. Then it was another month before I could see the specialist

8 Department of Defence, *Submission 38*, pp. 2-3.

9 Department of Defence, *Submission 38*, p. 5.

10 Mr Brian Freeman, Director, Centori Pty Ltd, *Committee Hansard*, 25 March 2013, p. 9.

11 Name withheld, *Submission 7*, p. 1.

> again, and then I had to see another doctor. … The MRI would have been at least a year after the initial injury, if not longer.[12]
>
> It was not until late 2010 that I could not handle anything anymore. I went into the RAP in Townsville and saw the doctor to see if he could point me in the right direction to start getting fixed up. He told me I had poor abdominal strength and I needed to work on my core strength. He booked me in for an X-ray, but nothing was followed up.[13]
>
> At the moment we are having a bit of trouble because it takes so long to see a doctor and some of us have quite bad injuries.[14]

4.19 Defence Families of Australia (DFA) highlighted the importance of provision being made for members to obtain independent medical assessments from specialists of their own choosing.[15]

4.20 RADM Walker was aware that there were still some transition issues in that the on-base workforce, particularly in Townsville and Darwin, were still not meeting the Key Performance Indicators (KPI) that Defence had stipulated in the contract. She advised that Defence is working with the contractors to address those issues. RADM Walker stressed that health care is being delivered in a timely fashion for people who need urgent health care.[16]

4.21 Defence submitted that for on-base non-urgent medical appointments, of a total 51 facilities, 80 per cent had improved or not changed waiting times following the new contract. For non-urgent on-base mental health appointments, 85 per cent of 40 facilities were improved or unchanged; for non-urgent psychology appointments, 79 per cent of 43 were improved or unchanged; non-urgent physiotherapy appointments, 80 per cent of 40; and likewise for non-urgent on-base dental appointments.[17]

4.22 In terms of off-base waiting times, Defence advised that when referring an ADF member to an external specialist, the referring health practitioner is required to identify the referral priority (Routine, Clinically Urgent or Operationally Urgent) and the Service Delivery Priority (Priority 1: Less than 7 days, Priority 2: 7 to 28 days and Priority 3: Greater than 28 days). The Central Appointments Team then books specialist appointments in accordance with the referral and service delivery priority identified by the

12 Soldier A, *Committee Hansard*, 25 October 2012, pp. 2-3.

13 Soldier B, *Committee Hansard*, 25 October 2012, p. 4; Regimental Aid Post, the unit medical centre.

14 Soldier J, *Committee Hansard*, 26 March 2013, p. 13.

15 Defence Families of Australia, *Submission 8*, p. 2.

16 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 7.

17 Department of Defence, *Submission 38*, p. 4.

referring health practitioner. Defence advised that the average national wait time for an appointment with the following medical specialists booked through the Central Appointments Team is:

- Orthopaedic Surgeon - 16 days (business days);
- Dermatologist - 22 days;
- General Surgeon - 17 days;
- Obstetrician/Gynaecologist - 18 days; and
- Otolaryngologist/Head Neck surgeon - 22 days.[18]

4.23 Defence went on to advise that Joint Health Command does not provide health support in the operational setting. This is the domain of the single Services, however, Joint Health Command supports the generation of ADF operational capability. Joint Health Command provides ADF health personnel with access to training which ensures that they can deliver health care while in the field, air and at sea during operational and training activities or when in the garrison health facilities. This training covers a number of areas including combat first aid, care of battle casualties, emergency/trauma care and mental health care and support.

4.24 Commander Joint Health, in her role as Surgeon General of the ADF, also has technical responsibility for health care in the deployed environment, and exercises this responsibility through the development of policy and doctrine, and management of operational health capability requirements. This work is undertaken with input from the single Services.[19]

4.25 In response to a question on the implications of Defence budgetary reductions, RADM Walker said:

> There are no treatment services that are not provided on the basis of any budgetary restrictions. We have never refused anyone treatment.[20]

4.26 Likewise, Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, said to the Committee:

> The Chief of Army's very clear. We will support operations and we will support our wounded.[21]

4.27 Finally, Defence advised that they are responsible for the health care of serving members and the provision of all ancillary support services resulting from a health issue. The Department of Veterans' Affairs (DVA)

18 Department of Defence, *Submission 38*, p. 5.

19 Department of Defence, *Submission 17*, pp. 3-4.

20 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 8.

21 Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, *Committee Hansard*, 19 March 2013, p. 8.

will provide compensation and other support for a work related wound, injury or illness but not health care or rehabilitation until the agreed point of transition from the ADF.[22]

Reservists

4.28 Reservists serving on Continuous Full Time Service (CTFS) are provided with the same level of health services as Permanent Force members. When wounded, injured or suffering an illness resulting from Defence service, health care for that injury or illness will be continued after the Reservist ceases to be on continuous full time service and resumes part-time service.

4.29 Reservists serving on other than CFTS contracts receive health care for injury or illness resulting from their Defence service until the transfer of the member into the military compensation system, administered by the DVA, is completed.[23]

4.30 DVA advised that a significant sub-group of those with operational service include reservists, with active reservists numbering 21,554 as at May 2011. Twelve per cent of this group had undertaken continuous full time service in the 12 months to May 2011, with a median period of service of 140 days. Sixty per cent had undertaken continuous defence service of five or more consecutive days in the same period, with a median period of service of 28 days.[24]

4.31 The Returned and Services League of Australia (RSL) South Australia Branch submitted concerns about the issues confronted by Reservists who, after decompression (the term for a programed period where members who have returned from operations de-stress in a controlled environment) immediately return to civilian work and tend to be forgotten by the ADF.[25] Likewise Associate Professor Susan Neuhaus CSC expressed concern about the psychological effects of service on Reservists because the visibility of that group diminishes as they leave service and moved back into the civilian community.[26]

4.32 One Reservist submitted that they are treated as second class citizens when health issues arise months or years after returning from operations. They argued that in the case of psychological trauma or other injuries, which often take some time to manifest, the ADF wants 'no part' of the

22 Department of Defence, *Submission 17*, p. 4.

23 Department of Defence, *Submission 17*, p. 3.

24 Department of Veterans' Affairs, *Submission 18*, p. 8.

25 Returned and Services League of Australia, *Submission 11*, p. 3.

26 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 18.

rehabilitation process except to possibly downgrade the member's medical classification and 'show them the door'.[27]

4.33 It was submitted that greater support must be given to Reservists following their return to Australia, particularly those who have deployed individually, without the support of a unit.[28] RADM Walker responded:

> We have some concerns about reservists…. If you are a reservist and you have gone back into your civilian occupation … it is … about identifying those people and how they access all the support mechanisms that are there. So, we are continuing to look at the reservist population.[29]

Defence civilians

4.34 The Committee also notes that many Defence civilians deploy as reservists and return to work within Defence as veterans, resulting in special management issues. The Committee heard of one instance where 'poor and totally inappropriate people management practises' were displayed while dealing with a reservist's operationally caused post-traumatic stress disorder (PTSD).[30]

Rehabilitation programs

4.35 Defence submitted that there are three complementary programs for the recovery and rehabilitation of ADF personnel and each has a different purpose and scope depending on the clinical, vocational and psycho-social needs of each individual. These are described below.[31]

ADF Rehabilitation Program

4.36 The ADF Rehabilitation Program is delivered by the Garrison Health Organisation and provides an occupational rehabilitation service. This includes the coordination of care through Comcare approved rehabilitation consultants, who are the conduit of information between other support Services, Command, medical and the member.

4.37 In addition, the ADF Rehabilitation Program provides rehabilitation assessments, rehabilitation programs and specialist assessments such as

27 Name withheld, *Submission 16*, p. 2.

28 Name withheld, *Submission 16*, p. 6.

29 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 9 October 2012, p. 3.

30 Name withheld, *Submission 16*, pp. 33-47.

31 Department of Defence, *Submission 17*, pp. 15-16.

home, workplace, daily living activities, functional capacity and vocational assessments. This program also provides for non-clinical aids and appliances.

Paralympics Sports Program

4.38 The Paralympics Sports Program, through an established relationship with the Australian Paralympic Committee, supports all serving ADF members with acquired disabilities to adopt an active lifestyle, regain their physical fitness and participate in adaptive sport right through to elite Paralympic sport.

Simpson Assist Program

4.39 Joint Health Command identified a rehabilitation capability gap relating to the overall clinical services for severely injured members and support to their families which resulted in the development of the Simpson Assistance Program. The program will deliver new recovery and rehabilitation services by developing a tailored, integrated and multidisciplinary approach to accelerated rehabilitation for seriously wounded, injured and ill members. Simpson Assistance Program initiatives will contribute to rehabilitation excellence through a focus on:

- a new Intensive Recovery Program to be trialled in Townsville and Holsworthy in 2013;
- new holistic psychosocial member and family support services;
- improved clinical treatment options;
- provision of meaningful engagement options to Defence members on rehabilitation;
- improved coordination of services (case coordination as well as a member's healthcare needs perspective);
- rehabilitation research investment funding; and
- an ADF Rehabilitation Strategy and improved governance and reporting.

Intensive Recovery Program

4.40 The Intensive Recovery Program is the major clinical effort within the Simpson Assistance Program. The Intensive Recovery Program aims to fill the void between the specialist rehabilitation services available through public/private partners and the general restorative therapies available through Garrison Health.

4.41 The Intensive Recovery Program commenced in February 2013 and is intended to develop a specialist and highly experienced rehabilitation team, and the required equipment and supporting facilities, to provide individually-tailored recovery programs to members with complex circumstances. The team will also provide a specialist advisory and assessment service within the region and nationally. Following a scoping phase, the Intensive Recovery Program will be piloted over 18 months, in Lavarack Barracks (Townsville) and at Holsworthy Barracks (Sydney).

Support for Wounded, Injured or Ill Program

4.42 In late 2010, a review of practices to support personnel moving to civilian life found that, while the system supporting these personnel was generally good, it was inherently complex and improvements could be made. The aim of the review was to support the development of a seamless and integrated support process for injured or ill ADF personnel.[32]

4.43 An analysis and identification of gaps in the support to ADF wounded, injured or ill personnel resulted in DVA jointly implementing the Support for Wounded, Injured or Ill Program (SWIIP) which is designed to take what is generally acknowledged as a good system and make it better.

4.44 SWIIP aims to ensure the focus is on the member and their family, that complexity involved in obtaining support is reduced, and that any gaps in support are closed.[33] The ADF aims to provide coordinated, transparent and seamless support to individuals during their service and after transition including by:

- Enhancing support for personnel with complex or serious medical conditions who are transitioning to civilian life;
- Improving information sharing between DVA and Defence relating to injury or illness;
- Simplifying processes involved in applying for an acceptance of liability for compensation; and
- Streamlining and simplifying compensation claims handling.[34]

4.45 RSL Victoria submitted that while SWIIP is a very good model, it appears that the partnership between Defence and DVA has 'some way to go' to ensuring the program is delivering best practice service.[35] Similarly, RSL

32 Department of Veterans' Affairs, *Submission 8*, p. 15.

33 Department of Defence, *Submission 17*, p. 16.

34 Department of Veterans' Affairs, *Submission 8*, p. 16.

35 Returned and Services League of Australia, *Submission 11*, p. 4.

National Headquarters believes that, whilst there have been significant improvements in the management of ADF personnel wounded and injured on operations, they submitted that there were still 'many areas' which were problematical and needed to be addressed.[36]

Army – Support to Wounded, Injured and Ill Program

4.46 Army – Support to Wounded, Injured and Ill Program (A-SWIIP) facilitates the effective management of seriously wounded, injured and ill Army personnel.

4.47 Defence submitted that responding to the needs of a seriously wounded, injured or ill member and their family necessitates the coordinated and focussed efforts of the chain of command and supporting agencies to ensure that every member returned to the workplace after an injury or illness contributes to ongoing capability.

4.48 The framework of A-SWIIP is intended to ensure that Commanders are able to mobilise and coordinate all the resources required to support their wounded, injured or ill soldiers. Commanders appoint a Unit Welfare Officer as the soldier's primary contact to access local services and oversee the Welfare Board process.

4.49 Welfare Boards with multidisciplinary representation are conducted regularly to track progress, coordinate support and identify any issues to be resolved.

4.50 Army Member Support Coordinators are regional subject matter experts on casualty management. They provide the member and unit an established point of contact to assist with provision of aids for independent living, access to compensation forms and assistance in meeting travel and accommodation requirements.

4.51 The A-SWIIP framework functions to manage seriously wounded, injured or ill soldiers requiring convalescence, hospitalisation and/or significant assistance with activities of daily living.

4.52 The three broad levels of management are:

- normal medical management – applies where no medical employment classification (MEC)[37] action is required and supported by usual command arrangements;

36 Returned and Services League of Australia, *Submission 11*, p. 6.

37 Medical Employment Classification (MEC) - MEC 1: Fully Employable and Deployable, MEC 2: Employable and Deployable with Restrictions, MEC 3: Rehabilitation, MEC 4: Employment Transition, MEC 5: Separation.

- standard rehabilitation – applies to members who are classified as 'MEC 3' for periods up to 12 months and managed via Unit Welfare Boards; and
- extended rehabilitation – applies to members with severe wounds, injury or illness and is managed via Individual Welfare Boards.

4.53 Extended rehabilitation is a two year program designed to provide time in which to evaluate the member's ability to be retained in their previous trade, retrained or transitioned. Options exist for a further three year extended transition period focused on vocational/civil employment skills and education. This phase prepares the member for separation from Army.

Navy SWIIP initiatives

4.54 Navy has stood up similar processes to Army including Member Support Coordination officers. During the initial phase of the wounded or injured member's treatment a medical employment classification determination is made and this is the authority to administratively post the member to the nearest Navy Personnel Support Unit. Defence advised that currently, the Member Support Coordination officers will be the liaison between the medical facility and Command. The Commanding Officer of the Navy establishment in which the Personnel Support Unit is located has the ultimate responsibility for the health and welfare of the member under their command.

4.55 The Member Support Coordination officers will continue in the liaison role between the appointed Joint Health Command Rehabilitation Consultant and the Personnel Support Unit once the member has been discharged from hospital and commences rehabilitation. The Member Support Coordination officers coordinate with the member, the member's next of kin and the Rehabilitation Consultant to ensure all non-health agency or other authorities' actions are coordinated to align with the healthcare of the member. The Member Support Coordination officers will ensure that the member or their representative is visited by DVA On Base Advisory Service (OBAS) personnel for the processing of DVA compensation claims. The Member Support Coordination officers ensure that the member's care and rehabilitation is raised for discussion at the member's parent unit Command Focus Group. On behalf of Command, the Member Support Coordination officers ensure that periodic case conferences are convened to track the progress of their care and have the member, their representative and other key stakeholders agree to treatment/rehabilitation course of action.

4.56 If the member's medical condition indicates that a return to work in their current or alternative employment is likely, a return to work strategy is planned at one or a series of Case Conferences by the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer. In addition to the active clinical rehabilitation of the Navy member, the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer ensure that the member has 'meaningful engagement' during periods when they are not undergoing actual rehabilitation treatment.

4.57 If the member will not be able to return to work in the Navy, a transition timeframe is developed to ensure a strict succession of actions are implemented to ensure the smooth transition of the member. These are coordinated by the Member Support Coordination officers with oversight from the Personnel Support Unit Case Officer. These actions include, but are not limited to resettlement counselling and liaison.

Air Force SWIIP initiatives

4.58 Air Force intends to establish a Member Support Coordination Office incorporating the existing Compensation Claims Liaison Officer-AF. It will encompass both compensation claims support and the Member Support Coordinator function. The Member Support Coordination Office will assist commanders with the effective management of members with complex health circumstances and link into the Soldier Recovery Centres where required. This will ensure that all relevant support services are in place for the member. The dual role of the Member Support Coordination Office will also ensure that these members will receive appropriate and prompt compensation assistance.

4.59 Air Force is also in the process of establishing Individual Welfare Boards for individual case management of Air Force people. These Boards will be conducted at unit level and will allow a member's commander to consider all aspects of a member's health and wellbeing so that appropriate action is taken to ensure the best outcome for the individual.[38]

Physical rehabilitation and medical treatment

4.60 The Committee heard that, generally speaking, the military view physical wounds and certainly combat related injuries as 'a badge of honour'.[39] Of

38 Department of Defence, *Submission 17*, pp. 16-18.

39 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 1.

more concern to the Committee is how members who are wounded or injured convalesce and recover. The Committee heard evidence that the opinion of the standard of medical support provided by the ADF can vary from individual to individual. The RSL believes that the overall treatment and support of ADF personnel wounded and injured on operations is managed well by the ADF.[40]

4.61 Some individuals reported very positive experiences to the Committee.[41] Others, however, felt their career management and treatment has been appalling[42] and mismanaged:[43]

> Unless you are missing a limb — something which they can physically see — you are in the back corner.[44]

4.62 Additionally, evidence provided to the Committee suggested that some members are bastardised, receive threats and are accused of malingering while undergoing rehabilitation and discharge. The Committee heard that in some instances the way that injured soldiers are treated is 'truly disgusting'; and that the system is 'broken with rampant and unchecked corruption'.[45]

4.63 Associate Professor Malcolm Hopwood, Clinical Director of Austin Health's Psychological Trauma Recovery Service (PTRS) told the Committee that he considers it desirable that individuals who have both physical and mental health difficulties receive integrated physical and mental health care. He gave evidence that rehabilitation care for physical health can be integrated well with mental health care.[46] Go2 Human Performance also highlighted the importance of an 'integrative' approach to rehabilitation.[47]

4.64 Having interacted with a great number of wounded and injured soldiers while providing adventure training, Mr Freeman ventured the opinion

40 Returned and Services League of Australia, *Submission 11*, p. 2.

41 Name withheld, *Submission 6*, p. 2.

42 Name withheld, *Submission 14*, p. 1.

43 Name withheld, *Submission 7*, p. 1.

44 Soldier M, *Committee Hansard*, 26 March 2013, p. 11.

45 Name withheld, *Submission 7*, p. 1.

46 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 2.

47 Go2 Human Performance, *Submission 29*, pp. 2-3.

that a great many veterans with physical wounds also have mental wounds to some degree:

> Every Wednesday morning we have sessions with our adventure conditioner. Most of the soldiers in there are suffering from post-traumatic stress, diagnosed or undiagnosed.[48]

Facilities

4.65 The Vietnam Veterans' Association of Australia submitted that, while expanding the availability of dedicated repatriation-specific hospitals and convalescent facilities is not justifiable, the high standard of care set by these types of facilities should be mandated in caring for wounded and injured veterans.[49]

4.66 Soldier On submitted that the bulk of the rehabilitation equipment used by recuperating wounded and injured within private hospitals is generally supplied and supported by the hospital or, in many instances, has been bought through private fundraising. Organisations such as Soldier On work to fundraise and provide additional specialised rehabilitation equipment to private hospitals.[50] Professor Leahy told the Committee that Soldier on are investigating putting similar machines in troop concentration areas around Australia.[51]

4.67 Sergeant (Sgt) Craig Hansen from 7th Battalion the Royal Australian Regiment told the Committee that the Defence Housing Authority had become very responsive to the needs of wounded and injured members.[52]

Malingering

4.68 The Committee heard some evidence that individuals with real physical injuries are sometimes suspected of malingering, or at least of deliberately letting their mates down. One soldier reported that he was treated like an outcast because he was incapable of doing his job and was rubbished and ostracised by the hierarchy within the unit and treated poorly, he said,

48 Mr Brian Freeman, Director, Centori Pty Ltd, *Committee Hansard*, 25 March 2013, p. 7.

49 Vietnam Veterans' Association of Australia, *Submission 27*, pp. 3-4.

50 Soldier On, *Submission 15*, p. 4.

51 Professor Peter Leahy, Chairman Soldier On, *Committee Hansard*, 27 November 2012, p. 3.

52 Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 25.

mainly out of ignorance. The Committee heard that the attitude within that particular unit had, however, been dealt with.[53]

> There is a stigma in the Army if you are broken: you are a malingerer. It just keeps going. It is more of an old-school thing.[54]

Equipment issues

4.69 Mr Rod Martin, the Director of Go2 Human Performance, told the Committee that lower back pain and neck pain were the most common presentations to their clinic. He attributed this to the weight of the helmets worn, and equipment carried, by soldiers on operations.[55] Indeed, the Committee heard from several witnesses regarding the weight of equipment that was required to carried:

> I weighed my kit over there — body armour, weapon, and carrying all the equipment stuff that went in for all that. It weighed 51 kilos, which is more than half my body weight, and we did 15- to 20-kilometre patrols with that.[56]

4.70 The Committee heard also, however, that equipment is being continually improved and lightened, and that by 2012 body armour and operational specific equipment 'changes were quite significant, and they had come a long, long way' and that while body armour was always going to be relatively heavy, the fit of body armour had been greatly improved.[57]

4.71 One soldier suggested using 'quad bikes', or at least smaller tactical vehicles, to carry heavier equipment.[58] The Committee decided that this was beyond the scope of the terms of reference of the Inquiry (as with the issue of Army's decision to remove berets as standard headwear[59]).

4.72 The Committee heard that 'blast gauges' had been issued to soldiers to record blast and shock waves and Mr Simon Bloomer, Executive Officer of Carry On (Victoria) said that it was a significant step forward.[60]

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53 Soldier F, *Committee Hansard*, 25 October 2012, p. 13.

54 Soldier E, *Committee Hansard*, 25 October 2012, p. 13.

55 Mr Rod Martin, Director, Go2 Human Performance, *Committee Hansard*, 25 March 2013, p. 4.

56 Soldier J, *Committee Hansard*, 26 March 2013, p. 2. See also: Soldier M, *Committee Hansard*, 26 March 2013, p. 2; Soldier P, *Committee Hansard*, 26 March 2013, p. 2; and Soldier J, *Committee Hansard*, 26 March 2013, p. 6.

57 Soldier P, *Committee Hansard*, 26 March 2013, p. 2; Soldier N, *Committee Hansard*, 26 March 2013, p. 3; Soldier J, *Committee Hansard*, 26 March 2013, p. 5.

58 Soldier N, *Committee Hansard*, 26 March 2013, p. 6.

59 Soldier M, *Committee Hansard*, 26 March 2013, p. 13.

60 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 28.

Committee comment

4.73 The Committee believe that for the most part there is a general acceptance of legitimate physical and the need for appropriate rehabilitation within the ADF. One soldier commented that:

> I have not really experienced any sort of stigmatising because of my injuries. There is always the odd bloke having a joke, 'Ya 'lingerer!' or whatever else. There is always going to be a bit of that, but generally, throughout, I feel everyone has been supportive, from the rank onwards. They acknowledge that I have an injury and that that injury needs time and effort to be rehabilitated to whatever standard I can get it to.[61]

4.74 The Committee is concerned, however, about the general state of garrison health support, particularly given the reports of time taken to receive non-urgent treatment, not just for members wounded or injured on operations, but for all ADF members.

Recommendation 5

The Committee recommends that the Department of Defence annually publish detailed written assessments of garrison health care contractor key performance indicator statistics. The Committee further recommends that the written assessments include the results of an ongoing survey of Australian Defence Force personnel regarding their experiences with the performance of garrison health care contractors.

4.75 The Committee notes that Defence is aware of the issue of access to support mechanisms for Reservist post deployment and is nonetheless concerned that Reservist support needs are not being met.

Recommendation 6

The Committee recommends that the Department of Defence address the shortcomings in Reservist post-deployment support mechanisms identified in this Inquiry as a priority.

61 Soldier I, *Committee Hansard*, 25 October 2012, p. 12.