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Changing attitudes to mental illness in the Australian Defence Force: a long way to go…

Dr Edward Scarr
2015 Australian Parliamentary Fellow

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Cover image: Australian soldiers at the Australian War Memorial, Canberra.

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List of interviewees

Members of Parliament

1. Gai Brodtmann MP ALP Canberra ACT
2. Warren Entsch MP LP Leichhardt QLD
3. Hon David Feeney MP ALP Batman VIC
4. Ewen Jones MP LP Herbert QLD
5. Melissa Parke MP ALP Freemantle WA
6. Hon Stuart Robert MP LP Fadden QLD
7. Luke Simpkins MP LP Cowan WA
8. Andrew Wilkie MP Independent Denison TAS

Senators

9. Senator Chris Back LP WA
10. Senator David Fawcett LP SA
11. Senator Jacqui Lambie IND TAS
12. Senator David Leyonhjelm LDP NSW
13. Senator Barry O'Sullivan NP QLD
14. Senator Linda Reynolds LP WA
15. Senator Peter Whish-Wilson GRN TAS
16. Senator John Williams NP NSW

Australian Defence Force/Department of Defence

17. Air Chief Marshal Mark Binskin, Chief of the Defence Force
18. Brigadier Mark Brewer, Director General Training
19. Lieutenant General Angus Campbell, Chief of the Army
20. Cathy Davis, Director National Operations Defence Community Organisation
21. Wing Commander Joanna Elkington, Defence Advisor to the Joint Standing Committee on Foreign Affairs, Defence and Trade (JSCFADT)
22. Major General PW (Gus) Gilmore, Commander Forces Command
23. Lieutenant Colonel James Kidd, Army Officer
24. Lieutenant Colonel Ian Langford, Army Officer

25. Major General Fergus (Gus) McLachlan, Head of Modernisation and Strategic Planning—Army
26. Dennis Richardson, Secretary of Defence
27. Colonel Nicole Sadler, Director Strategic and Operational Mental Health/Head of Corps Australian Army Psychology Corps
28. Major General Jeffrey Sengelman, Special Operations Commander Australia (SOCAUST)
29. Colonel Craig Shortt, Chief of Staff to the Vice Chief of the Defence Force
30. Rear Admiral Robyn Walker, Commander Joint Health and Surgeon General Australian Defence Force

Department of Veterans' Affairs

31. Veronica Hancock, Assistant Secretary Mental & Social Health Branch
32. Dr Stephanie Hodson, Mental Health Advisor
33. Major General Mark Kelly, Commissioner
34. Dr Graeme Killer, Principal Medical Adviser
35. Simon Lewis, Secretary DVA
36. Dr Brendan Nelson, Director of the Australian War Memorial
37. Craig Orme, Deputy President
38. David Roberts, advisor to Minister Michael Ronaldson

Medical profession

39. Professor David Dunt, Founding Director Centre for Health Policy Melbourne School of Population and Global Health, The University of Melbourne
40. Dr Andrew Khoo, Consultant Psychiatrist and Director Group Therapy Programs, Toowong Private Hospital
41. Professor Alexander 'Sandy' McFarlane, Director of the Centre for Traumatic Stress Studies, The University of Adelaide
42. Dr Dan Pronk, Regimental Medical Officer (Retd)

Allied health professionals

43. Paula Dabovich, The University of Adelaide
44. Professor David Forbes, Director Phoenix Australia Centre for Posttraumatic Mental Health Department of Psychiatry, The University of Melbourne

45. Kerry Howard, Principal Psychologist, Mindfully Well
46. Major Clint Marlborough, Army Psychologist, 2nd Commando Regiment (Retd)

Ex-Service Organisations (ESOs)

47. John Bale, CEO Soldier On
48. Alan Behm, CEO FearLess
49. Michael Dowsett, Defence Force Welfare Association
50. David Everitt, President of the Board RSL Care SA
51. Bob Johnston, Federal Secretary of the Totally and Permanently Incapacitated Ex Service Men and Women
52. Lieutenant General Peter Leahy, Chief of Army (Retd), Chairman Soldier On, Director of the National Security Institute, University of Canberra
53. Paul Patti, veterans advocate
54. Tony Ralph, President Legacy Brisbane

Veterans

55. Jon 'Irish' Hawkins, Army Officer (Retd)
56. Shaun Hughes, PTE Army (Retd)
57. Darren (pseudonym)
58. Samuel (pseudonym)
59. Troy Simmonds, SGT SASR (Retd)

Veteran case studies—pseudonyms (Appendix A)

60. Samuel
61. John
62. Sara
63. Charlie
64. Harry
65. David
66. Bill
67. Marcus
68. Denise
69. Garry
70. Susan

71. Walter

Other eminent persons

72. Adjunct Associate Professor James Brown, Army Officer (Retd), United States Studies Centre, The University of Sydney
73. Professor Tom Frame, Director, Australian Centre for the Study of Armed Conflict and Society (ACSACS)
74. Air Chief Marshal Sir Angus Houston (Retd)
75. Chris Masters, journalist and author
76. Frank Quinlan, CEO Mental Health Australia

Executive summary

The aim of this research is to highlight significant elements of the ongoing debate around mental health and the Australian Defence Force (ADF). It examines in particular, the attitudes towards service provision and the support available to serving and ex-serving ADF personnel, highlighting areas where improvements can be made. To do so, a qualitative methodology was chosen to allow for the cataloguing of a range of views from working professionals and veterans. These include senior members of the Department of Defence (Defence), the ADF, the Department of Veterans' Affairs (DVA), the medical profession (both clinicians and academics), members of Ex-Service Organisations (ESOs), politicians, allied health workers, journalists and veterans themselves. The aim was to highlight some of the most credible and trustworthy discourse on mental health and the ADF. The issue is currently attracting an unprecedented amount of attention from the media, the bureaucracy, the medical profession and parliament. There exist numerous ongoing challenges with regard to the health of military personnel and veterans, as evidenced by persistent and debilitating health concerns among these populations and by the open acknowledgement of a range of professionals working in the area.

A feature of debates about the mental health of serving and ex-serving ADF personnel is the apparent circular argument in the public discourse represented in the media which runs as follows: 'the government sent these men and women to war, they have come back broken and it is now refusing to look after them'. These attacks make the government and the bureaucracy more defensive and reactive, and these running battles come to dominate discussion. The victimhood and entitlement mentality this has been seen to foster is not what veterans groups say their members ultimately want, nor is it compatible with long-term positive health outcomes post-military service. A circuit breaker is required to turn these circular debates (those that begin with personal narratives told through the media to parliament which engages experts and the bureaucracy, and back again) into a linear model of independent research leading to the development of evidence-based and best practice policy and service provision. The current system is failing a minority of veterans, and the manner in which this issue is being addressed in public debates is proving ultimately unhelpful, with some proposed solutions actually being counterproductive. Space must be made for a discussion on strategies not beholden to entrenched bureaucratic models that do not adequately consider what help these target groups need, nor how to get it to them.

A minority of veterans has been (psychologically) injured during their time in the military, experienced difficulties during their transition to the civilian workforce and encountered problems with their DVA claims. It is important to note that the system has not failed the majority of serving and ex-serving military personnel. The focus of this research is on ways in which the needs of a minority of disaffected serving and ex-serving ADF personnel can be better met. This is informed by both a case study approach with a small number of such disaffected veterans, while contextualising these case studies with the views of professionals with subject matter expertise working in military (mental) health and related fields. While the sample size is very small, and caution is required in interpreting the findings, the accounts of the veterans interviewed do complement the views of experts consulted.

An independently planned research strategy, with input from practitioners and academics is a vital but missing part of what is occurring at present (comment by an interviewee for this research who chose to remain anonymous). This needs to be made a priority for government (same source). This would include an ongoing commitment to both qualitative and quantitative research designed to assess the needs of veterans in a way that genuinely engages the unique aspects of the culture of this population, informing the design of strategies for prevention, early intervention and treatment. At present, an independent research agenda does not exist separate from bureaucratic control. This must be informed by subject matter experts, open to external scrutiny where experts are encouraged to be critical of poor practices when they are identified.

An umbrella framework is required to ensure the numerous diverse groups working in this environment can make a meaningful contribution to a whole, to ensure a commonality of effort, to foster collaboration, innovation and development, and eliminate redundancy.[1] A starting point for the development of end-user focused solutions is the experience of serving military personnel and veterans. An appreciation of the experience of these populations, combined with the application of a rigorous research methodology is useful to better understanding the needs of veterans and the best ways of implementing treatment models. Much of the current debate prominently features highly emotive accounts of disaffected veterans, but without a framework through which to understand these personal narratives, combative and reactive cultures flourish. What is required is to recognise and do justice to the experiences of veterans—constituting a form of *unrefined truth* is the application of a methodological framework to transform these experiences from personal tragedies to starting points for the development of meaningful solutions.[2]

A key feature of the service model as it currently exists is the range of Ex-Service Organisations (ESOs) that have grown to fill the (perceived) void between services and support provided by Defence and those provided by DVA. While committed and capable people are working for the benefit of veterans, some of the activities in this space feed into the above circular narrative of entitlement and victimhood where veterans find themselves in groups that see DVA as the enemy with whom they must battle for benefits. A system-wide approach to these groups that plays a coordinating function and offers guidance and support is an essential but missing element of the current system.

Both the respective leaderships of Defence and DVA recognise the complexity of the issue. Since the early 2000s, both departments have released a series of strategies, plans and reports and have been the subject of numerous inquiries. Likewise, the parliament has taken an interest in the health and wellbeing of serving military personnel and veterans. While much progress has been made, a disconnect continues to exist between some of the services available and the intended recipient communities. A consequence of the outsourcing and divestment of health assets and services by both Defence and DVA over the last decade is that there is a perceived lack of internal accountability regarding gaps in service provision. While the states and private sector are the providers of care, no systematic approach exists to understand and meet the complex needs of (particularly contemporary) veterans.

The gamut of issues around mental health and Defence is complex, poorly understood and easily misrepresented. It is not the aim of this research to review and summarise these issues but to highlight some of the recurring themes identified by a broad range of stakeholders, 76 of whom are acknowledged on the following pages. Unique features of the military include it being the only profession that requires its workforce to train for and carry out the killing of people and the destruction of property as part of its core business. This is thought to carry with it unique challenges to the non-physical elements of the wellbeing of the men and women who choose this profession.[3] Recurrent issues highlighted by those who agreed to participate in this research include the persistent issue of stigma that surrounds reduced mental fitness, and the challenges of the transition period between a career in Defence and one in the civilian workforce, and the corresponding impacts on (mental) fitness.

An encouraging note is the work being done by the 2nd Commando Regiment and the approach it has taken to the mental fitness of its workforce. There are elements of this that provide an example of what is possible, albeit with a small and highly specialised

workforce of elite soldiers. This Regiment has been successful at substantially reducing the stigma around reduced mental fitness and offered meaningful support to transitioning members in a culturally relevant way. Among the strategies adopted by this group is the provision of services and support by beret-qualified members of their own unit who have had first-hand experience of service-related non-physical injuries. Following the example of this unit, an opportunity exists for the broader ADF to invest more resources and research into prevention including mental health first aid and mental health literacy.

The ideas presented in this monograph are suggestions and provocations, and as such, it seeks to make a useful contribution to this ongoing debate. It proposes a number of interventions to address the issues highlighted, as well as corresponding research and policy formulation. A space needs to exist that privileges the best ideas, where credible research can lead to the development of evidence-based policy and best practice solutions. The community's appetite for sensational media reporting (leading to reactive institutional responses and back again), and the fragmented nature of the current state of responses to this issue is not serving the best interests of Australia's military and veteran communities.

Introduction

> I think there is a question in this for all those politicians who collectively sent those soldiers to war, particularly those who shared the spotlight with them when they went. What have you done since, what are you doing now to help them deal with the price they have paid? (Kerry O'Brien, *Four Corners*, 9 March 2015[4])

This program, *Bringing the War Home*, and the questions raised by the host, Kerry O'Brien, are a useful starting point for this monograph. In attempting to hold the politicians to account in this way, and with the health and wellbeing of our serving personnel in mind, perhaps more questions might be raised about foreign policy decisions that commit our military to war. However, the danger exists that this approach will prompt a defensive response and will continue to perpetuate the circular argument that pits veterans against the bureaucracy, and continues to parliament only to be repeated again without any progress having been made. One positive to come from the stance taken by the media is that this issue is now being discussed more than ever before. The mental wellbeing of military personnel and veterans now occupies a prominent place on the media and political landscape. Part of that is the way in which this program was the catalyst for the ongoing parliamentary inquiry. Once again however, the adversarial committee setting may not be the most effective vehicle to break the model of debate circularity described above.

This monograph employs qualitative methods as well as ethnographic and phenomenological methodologies in its analysis of the prevailing views of experts and personal truths of those who have experienced a military service-related psychological injury. As noted, a useful starting point for discussion on the health and wellbeing of Defence personnel and veterans is the lived experiences of these groups themselves. To provide this context, the stories of 12 veterans are included in an Appendix to this monograph. While these men and women represent the reason for the interest and action on this issue, the very small number of veterans interviewed means that interpreting the findings requires caution. While their stories can be most usefully seen as an important first step in the creation of evidence-based and best practice policy solutions to address the issue of the effects of military service on wellbeing, caution must be exercised when making generalisations based on the experiences of these case studies. While these stories give much needed context to discussions around mental health and the military, they do not, in and of themselves, necessarily lead directly to

policy solutions or treatment models. Neither does having a career background in the military mean that an individual is uniquely qualified to speak on this issue.

Using these personal stories as a starting point to define the scope of this problem, this monograph considers the ways in which this issue has been treated within the bureaucracy. Both Defence and DVA have been actively considering the mental fitness of their respective client pools, as part of a larger picture of the wellbeing of these communities. The parliament has also taken an interest, evidenced by two recent parliamentary inquiries. While there is currently an unprecedented amount of interest in these issues, the veterans who agreed to be interviewed for this research described significant barriers to accessing care and support. They describe a system that treats them at times with suspicion, in which inadequate treatment options exist. They describe being frustrated with a process that effectively exacerbates their existing psychological injuries. If the debate is to move beyond the current circularity that pits the needs of veterans against the bureaucracy, the first step is recognising these problems.

While much of the available data used in the preparation of the following chapters relates to the Army, these issues are not solely an Army problem. Examples of the impacts of Navy and Air Force service have been used where available and it should be noted that the issue of mental fitness is not limited to any single service.

This monograph is divided into three parts. The first part places the issue of mental fitness and the military within a wider context of (mental) health and Australian society. It notes, however, aspects of this issue that are particular to military service. These include a growing appreciation of the fact that the military exposes its personnel to trauma and therefore experiences corresponding incidences of psychological injury; and that service in a totalising institution can significantly disrupt individuals' lives when that service comes to an end.

The second part maps the changing attitudes towards mental health and the ADF of a range of stakeholders. These include the federal parliament and the departments (both Defence and DVA). A growing awareness and increasingly sophisticated understanding of this issue is evident in the parliament, the military and the broader community. This corresponds with an increased level of services and support available to those who require it. Nevertheless, while the senior leadership of the ADF, Defence and DVA recognise the serious nature of the issue and are focused on helping those affected, these attitudes have not sufficiently permeated the low and mid-levels of their respective organisations. A disconnect has been noted between the attitudes of senior

leadership and the services available, with better outcomes for those affected. Encouragingly, there exists a tangible appreciation amongst the ADF hierarchy that attitudinal and cultural change is not a *found object*, and there is commitment to continuous improvement and *learning by doing* evident from within this group. Another limitation is that while there is some consensus on what constitutes best practice psychological and medical care, there is no such thing as best practice macro-level policy models. While lessons can be learnt from the examples set by our partners in the US, UK, Canada and New Zealand, global policy settings are thought to be too context specific to allow for the adoption of an off-the-shelf product to address detailed policy requirements.

The third part of the paper describes areas of significant progress and others where progress is required. The persistent issue of stigma acts as a reminder of the low starting point of knowledge and uninformed attitudes towards service-related psychological injuries. A hopeful note is struck by the 2nd Commando Regiment and its approach to dealing with the health and wellbeing of its workforce. Changing attitudes towards veterans has a shaping effect on broader attitudes towards service-related non-physical injuries. This monograph records examples of ESOs that provide an invaluable range of services and support to veterans. There is, however, a feeling that some advocacy and support groups appear to remain trapped in an entitlement mentality that sees DVA as the enemy with whom they must wage battles for compensation. Finally, the issue of preventative mental fitness will be introduced, investment in which is seen to have good prospects for improved outcomes.

The Government has not failed all veterans. The majority of ADF personnel go on to live productive and happy lives, having enjoyed their career in military service. Mirroring the attitudes of the broader community, attitudes in the ADF towards mental health have come a long way from a very low starting point. However, the results are not yet effective and without significant investment in this issue now, there is a risk that the mistakes of the Vietnam War will be replicated, creating another long legacy of psychological injury from recent and current deployments.

Methodology

A key component of this research is the recorded and analysed views of a range of stakeholders including members of parliament, military personnel and bureaucrats from DVA and Defence, medical professionals, representatives of Ex-Service Organisations, veterans, and other eminent persons. To achieve this, qualitative research methodologies and data collection techniques were employed. Interviews were conducted with over 100 people, 76 of whom are acknowledged on previous pages. The objective was to distil some common elements in the debate on mental health and Defence from among the many and varied (and often contradictory) views held by experts with different professional perspectives. Additional aims of this study included the generation of concepts that could indicate useful areas for exploration rather than developing firm recommendations. Interview-based research on a small scale is intentionally designed to generate concepts. As an exploratory study, the aim has been to formulate concepts rather than verify conclusions.

Attempting to get an accurate read on personal beliefs held by members of parliament involves some unique challenges. The need to rehearse party political positions, the lack of familiarity with specific policy detail, and simple time constraints and availability all hampered this process. Initially, all 226 parliamentarians were approached with a written survey designed to elicit both quantitative and qualitative data. However, the response rate did not yield a representative data set, so this approach was abandoned. A list of 41 parliamentarians who either had previous military service themselves or had addressed the parliament on the issue of the mental health of military personnel and/or veterans was then assembled and they were sent written invitations to participate in an interview (see Appendix D). Of the 41 who were invited to participate, 16 were interviewed. These interviews generally took place in the member or senator's parliamentary office, although a small number were conducted by phone. Other interviewees were approached directly because of their personal interest and/or professional expertise in the subject. All interviewees participated with the understanding that their comments would be confidential and only quoted or paraphrased with permission.

Ethnographic and phenomenological methodologies were employed to explore the experience of these target groups. Ethnography refers to the study of people and cultures (in this case military and veteran cultures) and the recording of knowledge and systems of meaning from within these cultural groups. It refers to the presentation of

empirical data to better understand the lives of the cultural group. Features of this methodology include the collection of unconstructed (mainly verbal) primary data, and the identification of patterns from within that data.[5]

Phenomenological approaches begin with a description of lived situations and avoid generalisations. The researcher reflectively analyses these descriptions before offering synthesised accounts such as the identification of general themes about the phenomenon. Importantly, the researcher attempts to go beyond explicitly stated meaning and access implicit meanings hidden within the discourse.[6] Through the collection and analysis of empirical data from a wide range of sources, this monograph aims to reconstruct key features in the lives of a very small group of veterans, including their experiences with changing states of mental fitness, potentially including interaction with a part of the (military and veteran) mental health system. The case study approach provides the advantage of recording the lived experiences of a group of disaffected former soldiers. A qualitative methodology was chosen as it is best-placed to highlight issues faced by a group of disaffected veterans. Limitations of this approach include the need to be cautious when interpreting the results and generalising from this very small sample to a larger group. This qualitative research methodology was designed to explore the following research questions:

- what are the unique features of the issue of mental health and the ADF? (current and ex-serving)
- what are the prevailing attitudes and issues around mental health and Defence identified by key stakeholders?
- what are the obstacles and opportunities in raising the tenor of debate on this issue?
- what roles do the ADF, Defence, DVA and the federal parliament play in furthering these debates?
- what are some areas for further consideration that require solutions?

In responding to these questions, an analysis is provided that examines the respective strategic thinking and mental health policy of DVA, as well as the ways in which this issue is addressed in the federal parliament. Analysis of the interview data also revealed some recurrent themes, a small number of which became the focus of the paper.

Terminology

The casual use of stigmatising language relating to mental health is everywhere. From throw-away descriptions of best friends as being totally *mad*, to a busy weekend as being *mental*. Much of the language that is commonly used to describe mental health conflicts with a focus on a strength-based and recovery-orientated outlook.[7] A focus on language that is respectful of people who have experienced reduced mental fitness and the promotion of communication that focuses on recovery and personal empowerment has all kinds of benefits. Correcting the terminology used is not about political correctness, but recognises that language has an impact on shaping and reflecting currents of thought and feelings towards this issue. It also sends an important message about considering those whose lives have been affected.

The terms 'mental illness' and 'post-traumatic stress disorder' (PTSD) are highly-stigmatising as they reinforce the 'illness state' and inadequately recognise the life of the person being described. They also operate to the exclusion of a focus on recovery and the potential benefits of an experience with reduced mental fitness. Preferred terms that were suggested during the course of this research include 'mental fitness' (Major General Jeffrey Sengelman), a term used in this report where practicable, and Operational Stress Injury (Peter Leahy—Chairman, Soldier On), both of which are intended to ground the language in a biological foundation. Lieutenant Colonel James Kidd stated, 'I believe "mental resilience" is a term that suggests a proactive disposition and is therefore more useful'. Others suggested a need to avoid stigmatising medicalised language altogether and talk about 'blokes feeling angry and thinking about stuff more than they used to' (Troy Simmonds—veteran). Another current serving military officer, Lieutenant Colonel Ian Langford, commented that the effects of war on the human mind are entirely normal and to be expected. As part of evidence to an inquiry in the 43rd parliament, the following was reported:

> Legacy noted that there have been attempts overseas to characterise mental health issues not as a disorder (for example, PTSD), but as a battlefield wound or operational injury.
>
> Legacy submitted that such an approach to terminology would help to normalise mental health wounds and injuries as part of battle, and be perceived as more honourable and easier to accept than something termed as a 'disorder'. They submitted that this could also assist families to convince their veteran partner to

> seek treatment and support as required. Legacy suggested terminology such as 'Battlefield Stress Wound', or 'Operational Stress Injury'.[8]

While care needs to be taken to ensure that people affected are not discouraged from seeking professional advice and support, believing that severe symptoms are normal, consistent terminology needs to be adopted that avoids language which fuels stigmatisation. It is also beneficial to avoid the word 'suffer' and the language of 'harm', and instead focus on the ways in which these experiences can potentially lead to growth in other ways and an ability to adapt to change. Suffering is a subjective experience; through discourse we impose suffering on people with PTSD, thus limiting the individual and society from a fuller understanding of this condition. The removal of judgemental labels might allow people to attach their own feelings to the condition, thus empowering them and allowing for hope and new meaning. PTSD may not be all about suffering; the pain may also result in personal and societal growth (Paula Dabovich—researcher, University of Adelaide).

PART I—THE SCOPE OF THE PROBLEM

The first part of this monograph places the issue of mental fitness and the military within a wider context of (mental) health and Australian society. It notes, however, aspects of this issue that are particular to military service. These include a growing appreciation of the fact that the military exposes its personnel to trauma and therefore experiences corresponding incidences of psychological injury; and that service in the ADF can lead to significant life disruption when that service comes to an end.

Defining the problem

> The public don't like how our vets are treated; don't send them to war and then refuse to look after them. *(Senator Jacqui Lambie)*
>
> …
>
> I have watched these issues chew people apart. *(Dan Pronk—army medical doctor, retired)*
>
> …
>
> There is stigma involved with sharing with strangers. They say there is no stigma but there is still. It is still a mindset amongst soldiers and officers generally of a person who can't sort out his own stuff. I have witnessed negative stigma from PTSD. People still whisper and spread stories. There is still not enough education in the public and so not as much empathy for people's situations. There are not enough services and support available for sufferers of PTSD. A lot of it is about mindset. Think of the soldier's welfare and what is best for them and their loved ones. You sent them there and when they return their lives are never the same.
>
> As a soldier, you are trained from recruit training to kill or subdue your enemy. To be the best and uphold the traditions of the Anzacs. As men, we are too scared to say we are not good enough or that we need help at times. We would die for each other but we will not talk about our fears to each other because the vulnerability and embarrassment is too much at times. This leads to disempowerment, isolation, confusion and despair where we are helpless. Many choose suicide to end it or live lives of quiet desperation. It affects the community at large. It needs community help. It needs mates helping each other and looking out for each other. It needs education and listening to the veterans. It needs funds for rehabilitation. *(Samuel—Appendix A)*

In addition to the contemporary popular narrative recorded on these pages, it is useful to consider the scale of this issue and briefly rehearse changing attitudes and from where we have come. The effects of military service on mental fitness are poorly understood. It is known that a career spent in the military has a significant shaping effect on the lives of the men and women who choose this profession. An age-old tension exists between capability and individual welfare—that is, between a commander's desire to maintain a fighting force and the desire to look after the welfare of individual members of that workforce. Another historical facet of the military and mental health has been the way in which those experiencing the negative psychological effects of war and military service have often been branded as cowardly and malingerers and dealt with as a disciplinary matter. Physical wounds were often revered; however, mental scars often brought with them humiliation and the taint of failure.

Elaborate propaganda and coercion strategies have been employed by governments and militaries to ensure the ranks of their fighting forces remained stocked. Examples include white feather campaigns and instilling shame around being labelled with the administrative term 'lack of moral fibre'.[9] Public attitudes and prejudices towards military-related psychological injuries have fluctuated. While in the US during World War II there was a growing appreciation that all military personnel were vulnerable, in Australia following the Vietnam War, the public appeared to have reverted to World War I thinking when military-related psychological injuries were thought to be due to a pre-existing condition rather than war trauma.[10]

Prevalence rates of mental ill-health in service personnel and veterans

While there are significant gaps in available statistics, what we do know comes from Defence and DVA-funded research, in particular the ADF Mental Health and Wellbeing Study 2010 and the Middle East Area of Operations (MEAO) Census and Prospective Health Studies 2013.[11]

Lifetime rates for mental disorders in the ADF are considerably higher than the Australian community with over 54 per cent of ADF personnel experiencing a 'disorder' in their lifetime.[12]

ADF males report higher rates of PTSD (8.1 per cent) than males in the general community (4.6 per cent). There is no statistical difference in the rate of PTSD between males and females. Trauma histories between ADF males and females do differ however, with ADF males more likely to report accidents and other unexpected traumas, while ADF females were more likely to report interpersonal traumas.[13] The Mental Health Prevalence and Wellbeing

Study highlighted that in addition to exposure to traumas from civilian life, ADF personnel are additionally exposed to job-specific trauma. The study also reports that 90 per cent of ADF personnel have experienced at least one traumatic event in their lives, compared with 73 per cent of an age and employment matched Australian community sample.[14]

Contemporary Australia

Mental health and the ADF is part of a much larger context of (mental) health and Australian society. This is a highly complex issue that has proven to be susceptible to hijacking in the past by special interest groups and certain professions. The Defence leadership is taking the issue seriously and understand that it is broader than simply a health issue. As a society-wide issue, prevailing attitudes remain dotted with significant stigma towards those affected. Additionally, the military is a culture that does not acknowledge weakness or inadequacy. The cultural change around destigmatising service-related reduced mental fitness has been slow.

For example, PTSD affects a much wider population than veterans of combat or Defence. First responders are routinely exposed to traumatic circumstances and Indigenous children are thought to have high rates of psychological injury as a result of exposure to trauma.[15] The state and federal police, Department of Foreign Affairs and Trade (DFAT) and aid agency workers are other groups thought to experience abnormally high rates of psychological trauma.[16] A unique feature of military service is that the military is the only organisation that requires its workforce to kill people and destroy property as part of their core business. Because of this, the training for and conduct of military service can result in *moral injury*, a condition to which other professions are not susceptible (Tom Frame—UNSW professor).

The fallout from unrecognised psychological injuries includes increased incidents of self-harm, alcohol and drug abuse, domestic violence, incarceration, homelessness, early death and suicide (Alan Behm—FearLess CEO). One observation is that ‘homeless, displaced veterans have replaced swagmen of a bygone era and are self-treating with suicide’ (Behm). A feature of debates around the above issues, however, is that little data exists to support claims being made about the prevalence of these kinds of consequences of military service. Defence and DVA are currently attempting to address this shortfall with several joint-funded research projects. A key informant raised doubt about the methodologies employed by some of the research currently underway and the extent to which it can provide an accurate read on these complex problems (source chose to remain anonymous). Another criticism of existing research programs is that they do not adequately account for the so-called ‘healthy soldier effect’ (Behm). Comparisons with the general population do not allow for the fact that defence members are a healthy group of people at recruitment. The accurate interpretation of

epidemiological data is critically important and this has not always been done well. Such data has in the past been skewed to shore up existing bureaucratic positions (Behm). For example, the ADF Mental Health and Wellbeing Study 2010 states that the 'prevalence of mental disorders was similar to the Australian community sample…', an interpretation of which may be that urgent action on ADF mental health is not required.[17]

While part of a much larger picture of (mental) health and the community, the mental health of current serving Defence personnel and veterans has some unique aspects. Young men, and an increasing number of women, are recruited and taught to see themselves as contributing to something greater, where their own health and ultimately their own lives become a tool of the government of the day. It is rarely explained in this way; it is assumed in the role these men and women take on. Once defence personnel are taught to put the system before themselves, they are exposed to a work environment that doctors know will make some of them unwell. The training and qualities that make good soldiers can be the very things that put these men and women at greater risk of harm, and leave them less able to seek help when it is needed. This monograph sets about framing this problem and its consequences before presenting some of the views of the experts who set the agendas around these issues.

While serving in a professionally satisfying and high-functioning environment, soldiers (particularly among the Special Forces community) are supported by their peers and feel a strong duty to project an image of strength and not let the team down. Anecdotally, ADF members believe that a diagnosis of mental illness will result in missed promotion windows, missed deployment opportunities and most likely, medical discharge. The stigma of 'mental illness', combined with the fact that it can be hidden, means that people are continuing on with untreated psychological injuries and other manifestations of reduced mental fitness. Upon leaving the military, individuals may find themselves in comparatively low-status unsatisfying jobs, and, feeling isolated from support, may then experience the psychological fallout of a career spent witnessing trauma. There is often a delayed onset of symptoms associated with PTSD and co-morbidities.[18] This creates a set of challenges that can include difficulties in linking exposure to trauma with (a delayed onset of) symptoms, both from the veteran's perspective and in official bureaucratic processes.

With low rates of mental health literacy and an inability to identify when help may be required, the situation may become chronic, with the individual feeling increasingly helpless before the case comes to the attention of the medical community or DVA. Records may be patchy and an already unwell veteran may find themselves having to retell their story numerous times in an adversarial setting where the onus of proof is on them to demonstrate they are deserving. The more tragic of these stories find their way into the media, and their

compelling nature and compatibility with sensational but easily digestible media agendas mean the story becomes one of 'this government sent these men and women to war, they have come back broken and it is now refusing to look after them'. Second order effects of this include industries of Ex-Service Organisations that have sprung up in large numbers to fill a (perceived) gap in care. While these groups are most often started by well-intentioned people motivated by helping other veterans, numerous problems have been identified with the current status of these groups (see section on ESOs).

Other features of this system include traumatised veterans appearing before Senate committees where committee members who are veterans themselves are repeatedly exposed to harrowing stories which may trigger the reliving of their own experiences of trauma. Such inquires pit generalist politicians against bureaucrats well-practised at deflecting attention and criticism with strategies such as ruling lines of inquiry outside of their respective administrative remits.[19] Most senior bureaucrats are not subject matter experts in mental health, meaning the responses they give often do not clarify anything or accurately inform the politicians regarding their concerns. Constant attacks and accusations (both by the media and politicians) have had the effect of making inherently insular cultures of the bureaucracy more defensive. The adversarial nature of the hearings only increases the defensive, 'bunker down'/'we're already doing that' responses. Linda Reynolds (Government Senator) commented: 'the behaviour of the popular media makes Defence even more reactive and defensive in the area of veterans' health'.

An independently planned research strategy, informed by subject matter experts (both academics and clinicians), is vital to properly understanding the situation, and needs to be made a priority. It should include both qualitative and quantitative research designed to assess the needs of veterans in a way that genuinely engages the unique aspects of the culture of this population and informs the design of strategies for prevention, early intervention and treatment. At present, an independent research agenda does not exist separate from bureaucratic control. The only reason for denying the publication or distribution of research should be security concerns. Academic research in the US, Canada and the UK is not subject to the same level of bureaucratic control as it is in Australia (Dr Alexander 'Sandy' McFarlane—psychiatrist). When politicians and journalists sense something is amiss, but cannot get straight answers, progress is stifled and the same circularity is perpetuated. A program of independent and best-practice research may be one key element in breaking the circular manner in which this issue is played out at present.

Anyone experiencing reduced mental fitness, including Defence members and veterans, is relatively powerless and while stories of wounded veterans are picked up by the media, it

remains the case that Defence and DVA do not really know what to do with serving members and veterans whose health has been adversely affected in this way. While Defence is focused on capability, injured veterans become an issue of secondary concern. While the leadership group of Defence is interested in this issue and has a genuine interest in better outcomes for members of these groups, a top-down approach is not the whole answer. Paula Dabovich (researcher—University of Adelaide) noted that you can have the best policies, but if they are not well-understood or accepted by the target populations, they are essentially a waste of time. A gap in the research exists regarding how soldiers feel about the treatment and services available, and what they actually want. 'We [the research community] need to listen to what soldiers actually want' (Dabovich). The claim being made here is not that policymakers should be dictated to by a small disgruntled group, but that research into culturally appropriate service provision is an important but missing component of a well-informed approach to improving the experiences of those who feel that existing services have not been designed with their needs in mind.

As Peter Leahy (Chairman, Soldier On) remarked 'we've got to keep talking about this issue'. Major General Gus Gilmore commented that it is the five per cent of veterans who are not receiving proper health care on whom we need to focus our efforts. Retired Army psychologist, Clint Marlborough, said 'there is a strong feeling among a number of quarters of these debates that the issue has not been dealt with properly and it is now time to do so'.

Part of this puzzle is the relationship between the federal government's coordination and state-based service provision. Mirrored in the organisation of the Returned and Services League (RSL), state-based health systems can be fragmented (source chose to remain anonymous) due to the nature of the systems that support them. Some, likewise, regard the federal system as fragmented in that Defence and DVA are separate and not always successful in working seamlessly together (ESOs have arisen to fill the gaps occurring between these organisations). From a political perspective, although the consolidation and coordination of these systems appears to offer efficiency dividends, this would require political will. A key informant in this research believes that part of DVA's role is to be a de facto health insurer in a system lacking systematic oversight and auditing (anonymous). A lack of coordination between federal, state and private sector health services was noted by the same informant.

First-hand accounts of personal impacts

In the following quote, the wife of an Afghanistan veteran describes the relationship between the (un)availability of physical rehabilitation services and mental fitness impacts:

> I think the ADF medical system needs considerable change overall. It's backward at best and risk-averse in the extreme. Some of the PTSD issues stem from service personnel being medically downgraded and considered unfit for their role, when the reality is with correct physio and support services there is no reason they can't continue in their role. I know a considerable number of ADF members who use outside services, and pay for them out of their own pocket, because the services provided by the army medically are inadequate and antiquated. Further overhaul of PT practices within the army and rehabilitation programs need genuine improvement. Having worked on an army base and seen the rehab for physical injuries it is hopelessly inadequate; with people not getting better physically, this is only going to add to mental health issues. *(Sara—Appendix A)*

The following is a first-hand account of the suicide of colleagues where PTSD is highlighted as a potential contributing factor:

> Yes, I have a lot of mates who suffered from PTSD. Some committed suicide but I'm unsure whether it was totally PTSD or that started the downwards spiral and drugs/alcohol, or something else, contributed to, or sped up, the process. I have mates at the moment who are suffering in some form or another and others I suspect, but haven't spoken to about it. *(Charlie—Appendix A)*

Here, the effects of poor mental health literacy and the resulting stigma are illustrated, as is an unwillingness to offer support to those who may really need it:

> Yes, and I was one of these people who looked upon it negatively as a younger soldier. Having gone through some of the experiences myself I could not see why people who signed up to do just that, could break easily. I never said anything and tended to move away from people who were suffering. These days I don't believe that, possibly because of some of the guys I used to look up to as a younger soldier who now suffer or/and because of the scale of it within Defence/ex-Defence. *(Charlie—Appendix A)*

The following is another example of the impacts that war-related trauma can have on the lives of those who experience it:

> My boss (Lieutenant) shot and killed a Taliban suicide bomber. [He] now suffers severe PTSD and struggles to live days without seeing him in his life. *(David—Appendix A)*

After having set the scene with these pages on the scope and unique features of the potential psychological effects of working in the military, the background to the research, planning and reviews in Defence, DVA and the Federal Parliament will now be considered in turn. These institutions have done impressive work around the issue of mental fitness and the military workforce. Care needs to be taken interpreting the above quotes taken from the very small

group of veterans who agreed to contribute to this research. Although, as noted, many of the sentiments expressed are reflected in the considered views of the working professionals with whom the researcher spoke.

Transition

A recurrent theme raised during interviews was that of transition back to being a civilian following a career in the military—often referred to as *separation*. This phase of a military career appears to have significance for debates around mental fitness and the military.

A significant feature of a military career is the reported effect it has on people when it ends. This relates to members from across the ADF, not only combat soldiers. Part of the trauma of military service and war appears to be the loss of the closeness and cooperation that it engenders.[20] It has also been theorised that after living an intense and interdependent lifestyle, the process of returning to the individual modern Western lifestyle can be brutalising to the spirit—feelings of alienation and loneliness are often seen to be associated with leaving a military environment:[21]

> The very nature of excellence as a combat soldier requires extremes of commitment and fusion of identity with the collective, yet simultaneously puts them [soldiers] at risk of injury and thereby involuntary discharge. This in turn can precipitate a sudden and unexpected shift in identity, embodied by a change of medical employment category within their units, followed by movement to a rehabilitation environment, change of employment and medical discharge. Research with soldiers who are discharged on medical grounds, confirms the high emotional impact…[22]

Discharge from the ADF is often a significant milestone in the lives of these 'transitioning' members. After a career spent inside an all-consuming institution, the process of becoming a civilian again can be traumatic for some. Part of this process of transition is leaving a highly satisfying and professional environment and beginning work in a low status and comparatively low-paid job. Sara, the wife of an Afghanistan veteran said:

> …helping ex-ADF members find work (particularly work that makes them feel valued). I have a friend who is a highly-qualified Combat Engineer, who did three trips to Afghanistan, left the army and went back to working at the freezer in Coles where he was before he joined—hardly a recognition of his skills and it hugely devalued him. *(Sara—Appendix A)*

A number of the veterans' stories included as case studies in this research raised the issue of employment post-discharge. A senior Defence officer remarked that he had been meeting with a NSW minister to devise a way to give veterans priority pathways into state emergency

services employment. Such a strategy was intended to act as a positive for both organisations, as veterans have already self-selected into the army and would have attributes valued in the emergency services, making it beneficial to both individuals and first responder organisations. A note of caution, however, is that the potential for exposure to trauma is actually greater in the emergency service sector than the military, and compared to Defence, the first responder organisations do not have comprehensive health systems for members. Stigma surrounding mental health is also a major problem. Perhaps a transition into other leadership roles would be a better outcome. Defence should prepare Special Operations Command [SOCOMD] operators (and by extension all ADF personnel) for careers after discharge (Dan Pronk). While the emotional distress of alienation and loneliness that may accompany transition can be deeply unsettling for some, the issue of employment was an immediate problem raised by numerous contributors to this research.

Many people interviewed for this paper felt strongly that Defence should play a more active role in the employment futures of members who are no longer 'fit' for active duty. In these cases, Defence could consider options for retaining the significant skills and expertise of its highly developed workforce and implement policies to support members being retained within the workforce in some capacity. Members may be better utilised within another area of the organisation, or allocated to a specialised 'arm' of the organisation. Alternatively, consideration may be given to the development of a program that sees the 'redistribution' of affected personnel into other supportive work environments, in which personnel feel that they are able to make a valuable contribution with their existing skill set in an effective and well-supported capacity (Kerry Howard—psychologist). (See the following section on the 2nd Commando Regiment for an example of how this approach has been successfully implemented).

A different approach might helpfully be taken to models of career progression and transition where workforce flexibility is achieved through the adoption of a range of solutions that assist in the transition process and leave veterans with the thoroughgoing impression that their futures and a high quality of life will be better served by a productive and functional engagement with the community, rather than a fight for pensions and a life of welfare dependency. For those experiencing chronic debilitating conditions, however, there may be little choice. Others may require their need for social inclusion to be supported in meaningful but less permanent ways.[23]

Soldier On has called for a 'universal transition program' for all separating ADF members to ensure that this group has effective access to study and meaningful employment post-discharge.[24]

PART II—CHANGING ATTITUDES

The second part of this monograph maps changing attitudes towards mental health and the ADF from a range of stakeholders. These include the Federal Parliament and the departments (the ADF, Defence and DVA). A growing awareness and increasingly sophisticated understanding of this issue is evident in the parliament, the military and the broader community. This has corresponded with an increased level of services and support available to those who require it. Nevertheless, while the senior leadership of the ADF, Defence and DVA recognise the serious nature of the issue and are focused on positive change in helping those affected, these attitudes have not sufficiently permeated the low and mid-levels of these organisations. A disconnect has been noted between the attitudes and support of senior leadership and the services available, with better outcomes for those affected. Encouragingly, there exists a tangible appreciation amongst the Defence hierarchy that attitudinal and cultural change is not a *found object*, and there is commitment to continuous improvement and *learning by doing* evident within this group. Another limitation is the incomplete evidence on what constitutes best-practice in terms of education, prevention and treatment.

The Parliament of Australia

The parliament, as a key national institution, plays a significant role in shaping attitudes on the treatment of military personnel and veterans, and their mental health care. However, there is no formal reporting mechanism between the bureaucracy and the parliament devoted solely to ADF mental health.

As seen following previous wars in which Australia fought, there is currently no shortage of attention and resources allocated to this issue. History has taught us, however, that this initial interest will wane. While popular attention given to the issue in recent months and years has been quite substantial, there has not been as much interest in it on the floor of parliament as media attention might suggest. However, this may not be the best indicator of parliamentary interest as the issue does come up in other ways within parliamentary processes. These include:

- on the floor of both houses of parliament (including statements from the minister, questions with/without notice, second reading speeches/debate)
- committee examination of legislation, referred inquiries, annual reports, budgets and white papers [Defence and Veterans' Affairs] (including by the Joint Standing Committee on

Foreign Affairs, Defence and Trade, and the Senate Standing Committees on Foreign Affairs, Defence and Trade)

- legislation (although in the Veterans' Affairs portfolio the introduction of new legislation is rare)
- Parliamentary Friendship Groups (Parliamentary Friends of Defence, and Parliamentary Friends of Mental Illness)
- the Prime Ministerial Advisory Council on Veterans' Mental Health and
- dialogue between MPs and the media.

The intention of this chapter is not to review all the above in a detailed systematic way, but instead to draw attention to some of the key forms debate on mental health and Defence takes within the Federal Parliament.

Influencing the attitude of the current parliament are those 21 senators and members whose biographical entry in the Parliamentary Handbook records military service.[25] While this service spans war and peacetime service from the 1970s to 2012 in both the full and part-time military, only a small number could be described as 'career soldiers', and fewer still have seen active war service.

In the Parliamentary Library publication *Commonwealth Members of Parliament who have Served in War* (2007) Lumb, Bennett and Moremon state:

> Of those Commonwealth MPs who were elected before 1970, a remarkably high percentage experienced war service—some before entering Parliament, some while they were members, and some after they had left the Parliament. Although the total number is uncertain, at least 265 (30.2 per cent) of the total membership of the Parliament between 1901 and 1970 gave war service at some stage of their lives. Of the total membership since Federation, at least 286 (19 per cent) did so. Since 1970, twenty-one, or 3.4 per cent of the total membership, have done so. [26]
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> …
>
> MPs who were servicemen prior to their entry into the Parliament have tended to be very involved in policy debates in relation to such areas as repatriation, conditions for returned servicemen, defence and foreign affairs.[27]

While on a much smaller scale, the latter observation holds true of the current parliamentarians who made their careers in the military before joining parliament. However, as noted in the Parliamentary Library research paper, the influence of those who served in war is much reduced, reflecting the comparatively small percentage of Australian society who has seen war. As the number of war veterans in the current parliament is limited, so is their influence.

Floor of parliament

The observations below are based on textual analysis of parliamentary debates from both the House of Representatives and the Senate during the current 44th Parliament. The search terms used in compiling this data were 'mental health' and 'defence' and related combinations on the Parliament of Australia website and in the 'ParlInfo' database.

The data has been grouped into like categories and includes:

- statements by the minister announcing the government's position and new policy initiatives
- the continuing influence of Vietnam War veterans
- the sometimes anecdotal accounts given in parliament
- lauding of the previous government's achievements
- the position taken by minor parties
- the theatre project *The Long Way Home*
- the perhaps self-fulfilling prophecies of some positions
- deeply felt personal views and
- the aspirational quality of some of the sentiments expressed.

Ministerial statements

During 2014, the Minister for Veterans' Affairs regularly addressed the parliament on the issue of mental health and Defence. Issues covered included the government's agenda; the launch of a promotional video on services available; a smart phone app with information on PTSD; and an initiative to write to all transitioning members with departmental information.

I am pleased to inform the chamber that today I am launching a video that will remind serving members that, while they may not need help or access to services now, they may need assistance in the future, and there are many avenues available to them to pursue. This video stresses that DVA and Defence have a shared responsibility to look after serving and ex-serving personnel and their families now and into the future. The video is just one of many activities being rolled out as part of a campaign to fully engage the Defence and veteran communities and their families by providing them with information on the support and services available to them.

In particular, the video provides details of nonliability health care, whereby many ex-serving men and women can get treatment for depression, anxiety, PTSD, and substance or alcohol misuse without having to lodge a claim or link their condition to service. This launch will take place at the second meeting of the Prime Minister's Advisory Council on Veterans' Mental Health, otherwise known as PMAC, which is taking place today. This video was one of the recommendations of the military compensation review with further engagement and awareness of what benefits are available. The aim of the video is to reinforce to current serving members that, no matter what stage of your career you are at, it is DVA and Defence's job to look after your family now and into the future, and is a reminder also that Defence looks after your health treatment when you are serving and, when you are discharged, DVA provides early access to health and support services. Both DVA and Defence have shared responsibilities, which both the assistant minister and myself take very seriously.

I am pleased to inform the chamber that the VVCS [the Veterans and Veterans' Families Counselling Service]has been exploring ways to improve awareness of the services it provides to veterans and their families. The VVCS has a prominent online presence, including a modern website and Facebook page. Today, it also announced the Support When You Need It campaign, which is targeted at those who have recently separated from the ADF to encourage them to contact the VVCS in tough times and to utilise the counselling and support services available to them. VVCS counsellors have an understanding of military culture and can help to address concerns such as relationship and family issues, anxiety, depression, anger, sleep difficulties, PTSD, and alcohol or substance misuse, with the aim of finding effective solutions for improved mental health and wellbeing.[28]

…

This weekend, right across Australia, all Australians will have the opportunity to welcome home those who served in Operation Slipper. There will be troop marches throughout the nation. I encourage all Australians to attend and support those men and women who were engaged in Operation Slipper. Many of those men and women may require now, or sometime in the future, assistance to deal with anxiety, stress or other

> mental health conditions. I have said to this chamber before that veterans' mental health is a matter of great personal importance to me and also to the government. I am therefore delighted today to launch a new smartphone app, called High Res, which continues the government's commitment.[29]
>
> …
>
> In relation to Senator Reynolds' question, it seems remarkable to me that those who were transitioning out of Defence could not be contacted by my department unless they actually lodged a claim. Ridiculous! Privacy laws precluded that. So I worked with the department, and the secretary will now write to every transitioning member telling them exactly what the department offers and, just as importantly, telling their families what the department offers. It has filled a massive gap, and ex-service personnel or those transitioning deserve to know what is available.[30]

Vietnam veteran influence

The Vietnam experience, powerful lobby groups, and a desire not to repeat the mistakes of the past continue to influence policy and service provision, including in the area of mental health:

> I will take this opportunity to place on the public record, the Vietnam veteran community is really still in a state of shock following the passing of Tim McCombe. He was a fearless advocate for the Vietnam veterans. As long as they are not listening, I said at his funeral that the four people who scare me most are my mother, my wife and my two daughters and after that it was Tim McCombe. You knew you had had a good clip around the ears from Tim if you deserved it. He had no fear and no favour. He was a fantastic advocate and he will be very sadly missed. I know I speak for everyone at the table here in relation to that.[31]
>
> …
>
> Since becoming the Minister for Veterans' Affairs, and in the three years prior as the shadow minister, I made it clear that I was not prepared to see the mistakes of the past repeated when it came to the nation's treatment of its veterans, ex-service personnel and their families. The treatment of Vietnam veterans on their return remains a dark stain on this nation's history. It is something that must never be repeated. This philosophy underpins everything the government seeks to achieve.[32]
>
> …
>
> We view veterans' mental health as absolutely fundamental to where this nation is heading. We believe that early intervention is the key to helping these young men and

> women and their families. The Australian government is currently spending $166 million per annum, uncapped, on the mental health needs of our serving men and women and ex-serving men and women. Quite frankly, this nation cannot afford to repeat the mistakes of the past. What was done to those men returning from Vietnam so long ago now this nation simply cannot do to the young men and women returning from recent conflicts. We are determined to address their needs.[33]

As a senior bureaucrat commented (anonymously) during the research for this paper, the Vietnam veteran cohort needs to be treated very carefully in terms of service provision, but also to ensure that lingering resentments and suspicion of the government and bureaucracy do not poison the next generation of veterans.

Anecdotal

There are a number of backbenchers on both sides of politics who have taken a personal interest in the issue of mental health and Defence. Some draw on anecdotal evidence of conversations they have had within their own electorate and things they have heard in the media, while others take a broader view of the issues:

> However—and I had a detailed conversation with one veteran in particular—a number in our veteran community experience PTSD. We know that with the new cohort coming out of Afghanistan and Iraq—Afghanistan in particular—accessing a specific VAN [Veterans' Access Network] network shopfront is much easier for them than going into a DHS service. My view is that these people have sacrificed, or have been prepared to sacrifice, their life in defending of our country. I think that we owe it to them, notwithstanding that we understand the Australian government's decision, as I said, to consolidate its service, to provide accessible shopfront services so members of our veterans community who have served our country so well in conflicts feel comfortable accessing these services. If I could, on behalf of the Casey Regional Veterans Welfare Centre, I respectfully ask the government to reconsider its decision. It is in the best interest of our veterans that it does so.[34]

> …

> I want to talk about this very serious issue of mental health, which I was reminded of in recent days with the tragedy of the partner of Mick Jagger from the Rolling Stones and what he would be going through now. What a terrible outcome it is when people seem to have lost hope. I have been told—and make no mistake about it, I am no mental health expert, a doctor or whatever—from good source that mental health is actually an illness. It is like catching a cold or the flu. The pressures get you down and you become ill—and it can be cured.

> Just in the past week there has been a significant announcement by my colleague the Minister for Veterans' Affairs, Senator Michael Ronaldson. The minister has announced the establishment of a new prime ministerial advisory council with a renewed focus on mental health. …because life is a partnership and mental health is not a stigma.[35]

References to the previous Labor Government

There are some members of the Opposition who choose to engage the issue by rehearsing the achievements of the previous Labor Government. Both sides of politics are guilty of this tactic. While this is an accepted part of the functioning of parliament, it might be seen as subverting genuine bipartisan goodwill towards achieving outcomes:

> So while those opposite will continually seek to denigrate Labor's record, Labor's accomplishments, Labor's passion and Labor's commitment to our veterans and to our ex-service men and women, let that denigration be known for the furphy that it is. And let it be understood that Labor can point to an extraordinary record of accomplishment in this very important area of public policy, because those opposite—try as they might—do not have the single claim to be the custodians and defenders of our former service men and women, our veterans community. As we have seen over 11 long years, the Howard government did precisely nothing. And under the zealotry of people like Senator Minchin they made sure that doing nothing in this space was a matter of high principle for them. Labor has in fact delivered a whole series of reforms in this important space—reforms that mean investment, mean stronger commemoration of our military history, and mean that there are practical solutions delivering real benefits for our veterans every single day of the year.[36]

Minor party positions

There are some thoughtful voices which attempt to situate the issue of mental health and serving personnel and veterans in the wider context of the decision to send them to war in the first place. Echoing the question posed by journalist Kerry O'Brien, quoted at the front of this paper, is the following statement:

> The Australian Greens believe that we have, essentially, a twofold obligation to our serving personnel. The first is that we should never deploy them unless it is absolutely necessary. We are well aware that in the past 15 years the ADF have been deployed into three wars of choice. I do not propose to get into arguments about where that decision should lie, or even the merits of those particular deployments. But we owe it to them—in fact, I think it is our highest responsibility—not to throw them into harm's way unless there is the very best possible reason for doing so. Obviously, we strongly disagree with some of the decisions that have been made in the recent past.

> The second obligation we owe them is to look after them, both while they are on deployment and particularly when they come back. For anybody who is not aware of what I am talking about, view a *Four Corners* program that ran not long ago, or read Major General John Cantwell's book *Exit Wounds*, to get a vivid insight into what happens to some of these people who have been exposed to horrific violence—and these are some of the most highly-trained and disciplined people the ADF has—who, when they return, are basically unable to decompress and assimilate the things that they have seen and done, having been at very close quarters to people being killed or injured, or having suffering horrific injuries themselves.
>
> But nonetheless it is amazing TV fodder for politicians to wrap themselves up in the flag and stand in front of the troops before sending them off into harm's way. But it is much harder to find politicians who will stand up for people who are suffering inordinately once they return home.[37]

The Long Way Home

One idea that appears to have captured the imagination of a number of politicians was the ADF's theatre project, *The Long Way Home*:

> I also want to take this opportunity to mention *The Long Way Home*, a play that was showing around Australia earlier this year. Just as media has an important role in raising awareness, so too do the arts—and this was achieved through this wonderful production, *The Long Way Home*. The play was written by Daniel Keene in collaboration with the Australian Defence Force, and it takes the words and experiences of soldiers and builds them into a work that acknowledges the damage of conflict alongside the mundanity and sometimes thrill of soldiering. It highlights the unique challenges faced by our service men and women in their return to everyday life after operations around the world.[38]
>
> …
>
> On Saturday night I had the opportunity to join with the Governor-General, Quentin Bryce, the Chief of the Defence Force, David Hurley, the War Memorial Director, Brendan Nelson, the Chief of Navy, Ray Griggs, and several other people of significance within the defence industry at a presentation of what can only be described as a unique and inspiring theatre production called *The Long Way Home*. *The Long Way Home* is part of a performing arts program to assist the rehabilitation and recovery of men and women in the ADF who have been wounded or injured or have become ill in service. This is an extraordinary production and I would urge those listening to the broadcast tonight to look out for opportunities to see it in their own city when *The Long Way Home* tours throughout Australia.[39]

Self-fulfilling prophecy

While a number of politicians appear genuinely committed to improving the mental health care available to military personnel and veterans, to talk of 'constant mental and physiological impairments' and looking after this group 'until they are dead' potentially risks the issue becoming a self-fulfilling prophecy. There is a danger of unnecessarily encouraging a belief that military service damages some people for life and that they can only survive with the assistance of ongoing government support:

> In Labor's last budget, we committed a record $12.5 billion to veterans, including an additional $26.4 million over the forward estimates to expand access to mental health services for current and former members of the ADF and their families. Labor hopes that the Abbott government is able to work in a sensible and bipartisan approach in aiding in the proper repatriation and suitable care of our returning soldiers. I believe the project for 310 St Kilda Road to turn this building back to a safe place, a constructive space, for returned soldiers will help our heroes battle the constant mental and physiological impairments they face each day due to the sacrifices they made to protect our country.[40]
>
> …
>
> I have long taken the view—and I think it is acknowledged—that once someone goes through the recruitment gates, goes out to Kapooka and does their recruitment training they are potentially a client of the Department of Veterans' Affairs for the rest of their life. What we have to acknowledge is that once we accept someone into the Defence Force we see them as part of the family that we need to look after, ultimately until they are dead. That means ongoing care not only of them but also, in particular circumstances, their families.[41]

In what sounds like another self-fulfilling prophecy from a passionate supporter of veterans, this is obviously an attempt to foster a sense of 'the real cost' of war on the (mental) health of those who fight them, but there is something fatalistic and ultimately depressing about this conclusion. This is also sometimes the case when similar sentiments are expressed by veterans groups.

Independent voices

The following excerpts from Senate Hansard demonstrate the depth of feeling felt for the issue, reflecting a mixture of deeply-felt personal anger and a strategic attempt to draw attention to it:

> Shame, Binskin! Shame, Griggs! Shame, Morrison! Your years of service will be rightly tainted and stained by your compliance with a despicable government wage offer to people you are supposed to support and protect at all times.
>
> The reason all political parties, senior military and government bureaucrats want to cover up veteran suicide rate is that it is damming proof of their incompetence and failure to stand up for our diggers. Today, the Minister for Veterans' Affairs, Senator Ronaldson, rose in this place and talked about mental health, trying to give the impression he cares about veterans living with mental health illnesses.
>
> I almost bought what he was selling—the deep voice, the measured delivery. I have to admire the minister: he has almost mastered the art of faking sincerity.
>
> Mr President, I will not accept any more of the Prime Minister's or the Minister for Veterans' Affairs spiteful, illegal and discriminatory attitude towards people with mental illness or other disabilities.[42]
>
> …
>
> The Prime Minister must act now and sack Senator Ronaldson—I have asked for it in the past and I will continue to ask for it—and put someone in the position who at least actually give a shit about veterans more and does not worry about overseas junkets.[43]
>
> …
>
> Mr President, I ask a further supplementary question. Would the Minister for Defence agree that the transition period between defence and into veterans' affairs is an absolute failure?[44]

Aspirational

Some mentions in parliament are aspirational such as the 'passion' described below to make access to mental health services in remote locations as accessible as it is in urban areas. Likewise, the second quote outlines a proposal to fund veterans' pensions and improved mental health services using revenue from the (now repealed) mining tax.

> One of my passions is to make sure that access to good mental health services in regional areas of New South Wales like Gilmore are just as accessible for someone living in Ulladulla or Jamberoo as they are for a city resident and that young people, veterans and victims of domestic violence all get the very essential mental health care and guidance they need so their families never see the image that I spoke of earlier.[45]
>
> …

> Let me turn now to mental health. We could invest revenue from a decent mining tax—a tax over the mining of our shared resources—in proper reform of mental health services.
>
> Let me now turn to veterans' affairs. Revenue from an adequate mining tax could be used to introduce a fair and equitable system for veterans' pensions.[46]

The quote below is an example of the need for greater dissemination of information on this complex issue. While some MPs have informed themselves of the details, availed themselves of briefings, and have a working knowledge of the research around the issue of mental health and Defence, others are less familiar with this material. As a senior public servant (on the condition of anonymity) remarked in an interview for this paper:

> If an MP or Senator doesn't know how to ask for a briefing then what are they doing there? What more can I do for them? If they want to run a second rate institution then that's up to them. There are no excuses for politicians not to be informed, there are enough opportunities for them to inform themselves on this issue, as evidenced by those that choose to.

Psychologists recognise that PTSD is about exposure to trauma—which may or may not come from operational service overseas—although as demonstrated by these comments, this is not widely understood:

> It has been of interest to me in terms of post-traumatic stress disorder, PTSD. Some information that was made available to our committee recently was that more than 50 per cent of serving and retired military personnel who record the fact that they are suffering post-traumatic stress disorder have never deployed outside our country. I do not know the reasons for this, but what I do applaud is the funding that has been expended in trying to come to an understanding of why that might be the case.[47]

Previous committee inquiry

During the 43rd Parliament, the Defence Sub-Committee of the Joint Standing Committee on Foreign Affairs, Defence and Trade conducted an inquiry entitled *Care of ADF Personnel Wounded and Injured on Operations*, the report of which was released in June 2013.[48] The report included a chapter on 'mental health concerns' (pp. 49–74) and made four recommendations, namely:

- DVA accept complementary therapies (where an evidence base exists)
- Defence publish regular updates on research outcomes and program implementation

- Defence and DVA undertake a study of psychological support offered to partners and family and
- psychological first aid be made a research priority.

The government response of December 2013 either 'supported' or 'supported in principle' all four recommendations, but the government has been slow to act on them. Various groups remain frustrated that repeated inquiries do not appear to have led to substantial change.

Recent Senate committee inquiry

The Senate Foreign Affairs, Defence and Trade References Committee recently examined 'the mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment'. Submissions closed on 26 June 2015 and the inquiry reported in March 2016.

The inquiry homepage states:

> In terms of setting expectations, the committee emphasises that it is not in a position to address individual cases of mental ill-health and post-traumatic stress disorder (PTSD) among ADF personnel who have returned from combat, peacekeeping or other overseas deployment.
>
> As the terms of reference of the inquiry indicate, the committee's focus is on the mental health support, evaluation and counselling services provided by Defence and DVA, and the identification and disclosure policies of the ADF in relation to mental ill-health and PTSD.[49]
>
> …
>
> **Terms of Reference**
>
> 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.[50]

The inquiry received 76 submissions, held four days of hearings, and took additional evidence in camera.

Parliamentary inquiries allow for a more open discourse around the issue than may otherwise be possible. While the bureaucracy is sometimes seen to resist these opportunities, the range and number of submissions demonstrates that individuals and organisations want to engage with this process. Like every parliamentary process, it is not immune to political posturing, but as the instigator of this inquiry, Senator Whish-Wilson, commented in an interview for this monograph, a strong set of bipartisan recommendations will have the best chance of making a real and positive impact on this issue for veterans.

In responding to the inquiry and the interest it may generate, the minister is presented with an excellent opportunity to engage with many groups that can potentially counter the obfuscation of the departments (source chose to remain anonymous). This requires a willingness to openly engage in dialogue and not become defensive of existing practices. Another comment made during interviews for this paper by a senior member of the academic medical community (on the condition of anonymity) is that many experts chose not to participate because they fear recrimination from the bureaucracy that could affect future government-funded research. An extension of the same criticism is that there is a distinct lack of an information-sharing forum, independent from the bureaucracy, where expert advice can be provided in an honest and fearless manner. Parliamentary inquiries, as they are currently operated and run, do not solve this problem.

Parliamentary Friendship Groups

Another opportunity for debate and information-sharing on issues related to mental health and Defence are the Parliamentary Friendship Groups.[51] Although these groups do not routinely keep minutes of meetings or other records, and while they do not constitute a decision-making forum, they do provide a useful starting point where issues can be raised and agendas coalesced. The two groups most relevant to this issue are:

> **Parliamentary Friends of Defence**
>
> The objective of this group is to foster informed debate on defence issues and the strategic environment and to increase understanding of the challenges that face many current and former members of the Australian Defence force.
>
> **Parliamentary Friends of Mental Illness**
>
> The primary objective of the Parliamentary Friends of Mental Illness is to improve Parliamentarian's awareness and understanding of mental health issues that affect constituents in their electorates. This includes connecting Members and Senators with those living with a mental illness, their families and carers, as well as those working in the area of mental health including researchers, advocates and clinicians. In addition the group works to assist parliamentarians and their staff to be effective in supporting their constituents who are affected by mental illness.

Defence—policy background on mental health

A foundation for the development of ADF policy on mental health is the *National Mental Health Strategy* 1992.[52] It was a comprehensive framework to guide mental health reform. Its aims included the promotion of mental health in the Australian community, the prevention of mental disorders, the reduction of negative impacts where mental disorders do occur and the assurance of the rights of people with mental illnesses. In 1998 the second mental health plan was released, with subsequent versions released in 2003 and 2009. Most recently, the *Mental Health Statement of Rights and Responsibilities* was revised in 2012.[53]

In 2000, eight years after the release of the national plan, the Department of Defence released the inaugural edition of its Australian Defence Force Health Status Report.[54] This report aimed to present a summary of the health status of ADF personnel. It sought to provide a baseline against which future workforce health summaries could be measured, to identify health policy needs and recommend preventative health strategies. Its major findings with regard to mental health identified that available data was insufficient to provide a proper assessment of mental health status across the ADF. The most notable of the specific

recommendations to come from the report was for an integrated program to prevent, detect and treat mental illness. It also signalled that a comprehensive ADF-wide strategy and suicide prevention policy was being developed at that time.

This recommendation came to fruition in 2002 when the Joint Health Command Vice Chief of the Defence Force released *Mental Health Strategy—Live Well, Work Well, Be Well*.[55] This document recognised that mental health is a key element in the delivery of the personnel component to capability. It stated, for the first time, that the traditional medical model the ADF had previously been using as a basis for the delivery of mental health services, without a specific and targeted focus on mental health in its own right, was lacking and needed to be improved. While mental health care services had previously been provided to full and part-time ADF members, the strategy acknowledged that these services had been lacking in several key areas, including the coordination of service development and delivery, as well as the lack of standardisation in mental health policy.[56]

A key milestone in the evolution of mental health and Defence came with the 2009 *Review of Mental Health Care in the ADF and Transition to Discharge* by Professor David Dunt.[57] In his wide-ranging examination of mental health among serving and ex-serving members of the Defence Force, Dunt found that the arrangements in place compared favourably to other Australian workplaces as well as foreign military forces. He did go on to highlight 52 gaps in the delivery of mental health services and recommend reforms to rectify them. Broadly, the report highlighted a lack of funding for both the Directorate of Mental Health and Regional Mental Health Teams, and the need to further develop the overall strategy with regard to mental health. In his review, Dunt made the observation that these reforms would need to be marketed properly to ensure they had the maximum impact on members.[58]

Among other key themes identified by Dunt was the need to improve:

- privacy arrangements, disclosure and the sharing of mental health information
- the Medical Employment Classification (MEC) system as it relates to mental health
- the ADF rehabilitation program for mental health-related issues
- the transition from serving to non-serving Defence member
- communication with families of Defence members, particularly with regard to deployments and posting issues and
- the conduct of further mental health research and surveillance.[59]

The Department of Defence agreed to 49 of the 52 recommendations and partially agreed to the remaining three.[60] It promised a 'comprehensive plan to address the Dunt review recommendations' in May of the same year. It is interesting to note that while many key issues were identified by Dunt and his recommendations were agreed to by Defence, many of the same issues were identified by veterans as continuing problems in the six years since the release of the report in 2009. Among the outcomes of the reform agenda initiated by Dunt was the 2010 *ADF Mental Health Prevalence and Wellbeing Study* (MHPWS or 'the Study').[61] The Study claimed to have captured around half of all serving Defence personnel between April 2010 and January 2011 for the purpose of examining the prevalence rates of common mental disorders, optimal cut-offs for relevant measures and the impacts of occupational stressors. The Study compared results of Defence members with a community sample and found that overall rates of mental disorders were similar between the two groups.

The Study found that lifetime prevalence rates were higher in the ADF, but that experiences of mental disorders in the previous twelve months were similar in both samples. One in five ADF members reported experiencing a mental disorder in the previous 12 months. Approximately seven per cent of this number experienced more than one mental disorder at the same time. Women experienced the highest rates of anxiety disorders while men experienced the highest rates of PTSD.

Interestingly, the Study found that rates of alcohol disorders (dependence and harmful use) was 'significantly' lower in the ADF than the Australian community sample, with the majority of reported ADF alcohol disorders occurring in males in the 18–27 age bracket. It also found that there was no significant difference between Officers and ORs (Other Ranks) in the prevalence of alcohol use disorders.

The Study also looked at suicidality (ideation, planning, attempting) and found that while the rates of thinking of committing suicide and making suicide plans was higher in the ADF than the Australian community, rates of actual suicides were not markedly different between the two groups (p. 38). Additionally, the number of reported deaths in the ADF was lower than in the community. This does not, however, take account of the 'healthy soldier effect'—that only relatively young and healthy people are recruited and given better access to health services. It also does not account for those who may have become unwell or not coped with military life and were discharged. Therefore, the above statistics represent those who remain in the Defence Force, rather than the cohort who joined. The figures may therefore not represent the true burden of suicide that results from military service (Dr Alexander McFarlane).

Issues associated with stigma were also highlighted by the report. Over 27 per cent felt they would be treated differently as a result of a mental health-related issue. Approximately the same percentage reported fear of harm to their career because of perceived stigma. Perhaps the most telling statistic reported in the Study related to stigma was that approximately 37 per cent felt that the stigma associated with mental illness would reduce their deployability.

While mental or physical injury may inevitably interrupt an individual's career, the stigma associated with mental injury carries an additional burden. This stigma, combined with the fact that non-physical injuries can be hidden, motivates many to disguise a suspected psychological injury.

We know from the MHPWS that the prevalence of mental health disorders, such as PTSD, between deployed and non-deployed personnel did not differ. Because it is counter-intuitive and contradicts a substantial body of research that associates deployments with increased risk of poor mental health, a follow-up study was commissioned in 2013 by the Centre for Traumatic Stress Studies at the University of Adelaide entitled *Detailed associations between operational deployment and mental disorder in the Australian Defence Force: results from the 2010 ADF Mental Health Prevalence and Wellbeing dataset*. This study found that there were a number of factors that may explain this result. These include significant demographic differences that exist between deployed and non-deployed groups suggesting a 'healthy soldier effect'; as lifetime trauma history is strongly associated with mental disorder (particularly PTSD) regardless of deployment status, both deployed and non-deployed may be at a similar level of risk; that deployment may be a risk factor for *specific subgroups*, but not the entire deployed population.

The next phase in mental health for Defence was the production of the 2011 *ADF Mental Health and Wellbeing Strategy* ('the Strategy').[62] This was a result of both the Dunt Review and the *Prevalence and Wellbeing Study*. The Strategy claims to represent a whole-of-government approach as it draws on the Government's National Mental Health Policy (2008) as well as the Fourth National Mental Health Plan (2009–2014).[63] The Strategy claims to be based on a 'military occupational mental health approach' and states:

> Good mental health within the ADF operates on a continuum, starting with a person's entry into the ADF, their selection, assessment and suitability to the right job, through to preparing them to operate in risky environments. Furthermore, it provides the most effective treatment and rehabilitation if they become ill or injured so they can return to work as soon as possible. If the person cannot return to work in the ADF, as a last resort we will enable the individual and their family to make the transition to civilian life with

> the appropriate support in place to maximise their mental health and wellbeing. *(D.J Hurley, General, Chief of the Defence Force, p. iv)*

Treatment and support is reaching the majority, but as Major General Gus Gilmore quoted above stated, it is the five per cent of veterans who are not receiving proper health care on whom we need to focus our efforts. The Strategy does address the issue of stigma in a realistic way, acknowledging it as a major issue and expressing the need to overcome its effects, as well as break down the barriers that prevent individuals from seeking care. The Strategy states:

> Due to the unique demands of military service, the *ADF Mental Health and Wellbeing Strategy* is underpinned by a military occupational mental health and wellbeing *approach* based on the Military Occupational Mental Health and Wellbeing *Model.* (p. 7, emphasis added)

While these strategies, approaches and models sound impressive and speak (broadly) to the key issues in these debates, the (perceived) disconnect between the attitudes of senior members of the ADF and the experiences of soldiers on the ground remains an area of concern. The Strategy outlines the following seven priority areas:

- addressing stigma and barriers to care
- enhancing service delivery
- developing e-mental health approaches
- upskilling health providers
- improving pathways to care
- strengthening the mental screening continuum and
- developing a comprehensive peer support network (2011 *ADF Mental Health and Wellbeing Strategy*).[64]

A senior doctor working in veterans' health (who chose to remain anonymous) has noted a lack of systematic auditing of clinical service delivery, particularly since it was outsourced to Medibank Solutions, an organisation that he considers lacks the occupational expertise needed to deal with traumatic stress. A senior mental health clinician interviewed for this research stated that there are comparatively few mental health clinicians within Australia's

armed forces compared to our allies, and an assumption that these services can be purchased (anonymous).

The next piece of the puzzle regarding Defence and mental health policy is the *Mental Health and Wellbeing Action Plan 2012–2015* ('the Plan').[65] This plan came about as a result of the Dunt Review and the 2011 *ADF Mental Health and Wellbeing Strategy*. The objectives of the Plan were to finalise the implementation of the Dunt Review recommendations and achieve the strategic objectives of the Strategy. The Plan, prepared by the Mental Health, Psychology and Rehabilitation (MHP&R) Branch of Joint Health Command, provides more detail for the seven priority areas listed in the above Strategy. It listed individual goals under each of the seven sections and promised the delivery of an implementation schedule.

In 2014, a joint funding venture by both the Department of Defence and the Department of Veterans' Affairs saw the rollout of the *Transition and Wellbeing Research Program*, which was delivered by the Centre for Traumatic Stress Studies (CTSS).[66] This program claims to be the largest and most comprehensive study undertaken in Australia to date which examines the impact of military service on the wellbeing of Defence members and their families. The program promises to deliver three studies:

- *Mental Health and Wellbeing Transition Study*—the scope of this study is to survey 25,000 ex-serving ADF members who transitioned from serving between 2010 and 2014, 5,000 reservists and 18,000 currently serving ADF members.[67]
- *Impact of Combat Study*—looks at the wellbeing of 2,000 participants in the Middle East Area of Operations (MEAO) Prospective Health Study.[68]
- *Family Wellbeing Study*—conducted by the Australian Institute of Family Studies and focuses on the wellbeing of families of serving and ex-serving Defence members.[69]

The Australian Centre for Post-traumatic Mental Health (ACPMH) (now Phoenix Australia) was commissioned by the ADF to develop a mental health screening framework that could be used in both operational and non-operational settings across the three services to achieve improved screening outcomes across the ADF.[70] ACPMH determined that four health problems or disorders would be specifically targeted in the program: PTSD, depression, problematic alcohol consumption and suicide ideation. The framework concluded that all ADF members should be regularly screened, that new processes should be added to existing ones to achieve optimal screening levels, and that identifiable and anonymous screens should both form a part of the health care system. The framework utilised three instruments: the Posttraumatic Checklist (PCL), the Kessler Psychological Distress Scale (K10) and the

Alcohol Use Disorders Identification Test (AUDIT). For individuals who scored above the thresholds on any of these, an individual face-to-face interview was then administered. This included a standardised protocol which involved an assessment of suicidality and lifetime trauma exposure. All the above would operate on a 12 month cycle and have a tri-service focus.

In 2014 the Department of Defence released its *Alcohol Management Strategy and Plan 2014–2017* in which it provides a new strategy for alcohol management—reducing the harmful effects of misuse, enhancing capability, and reducing costs.[71] Among its stated objectives is 'systemic cultural change' around attitudes to the use of alcohol. The Strategy and Plan draws on evidence from the *National Drug Strategy 2010–2015* and the World Health Organization regarding harm minimisation with alcohol use.[72] Defence is currently working on an updated *ADF Mental Health and Wellbeing Strategy 2016–2020*.[73] Led by Joint Health Command (JHC), this will involve wide consultation with stakeholders inside and outside Defence. Defence also communicates with the parliament and the public on issues around the mental health of its workforce through the Defence and Joint Health Command annual reports and Defence white papers, as well as through submissions to former and current inquiries.

The Department of Defence submission to the recent Senate inquiry states:[74]

> **Mental Health, Psychology and Rehabilitation Programs**
>
> The delivery of mental health, psychology and rehabilitation services is enhanced by a number of specific programs and initiatives. These programs are described below.
>
> **General awareness and promotion resources and activities.** To aid in the mental health literacy and awareness for ADF members and their families, a range of promotion resources and activities are provided. These include topical fact sheets, Internet access to mental health information via the ADF Health and Wellbeing portal, provision of Defence help lines (All-Hours Support Line, '1800 IM SICK' and Defence Family Helpline) and, in partnership with DVA, a number of mobile applications. Aligned with annual international and national mental health awareness initiatives in October, the ADF Mental Health Day is a significant opportunity to further the understanding of mental health issues in Defence. (p. 12)
>
> …
>
> **Pre-deployment phase.** All deploying ADF personnel 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.

> The BattleSMART pre-deployment training is delivered in conjunction with a comprehensive pre-deployment training package.
>
> **Deployment phase.** For deployed members that are exposed to potentially traumatic events a Critical Incident Mental Health Support response is provided, consisting of a group psycho-education brief on expected trauma reactions, coping skills and methods on seeking support, followed by targeted individual screening questionnaire and screening interview. This aims to identify members that require immediate intervention or scheduled follow up and facilitate a return to pre-exposure functioning. Deployed high risk groups, those whose operational role 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 a Special Psychological Screen approximately mid-way through the deployment regardless of their actual exposure to potentially traumatic events. (p. 14)
>
> …
>
> Joint Health Command has developed the LifeSMART presentation which aims to increase member's individual psychological resilience and develop awareness of better ways of coping with the challenges of transition to civilian life. This presentation is delivered as part of a two-day ADF Transition Seminar which aims to ensure members and their families are well-informed, and which encourages them 'to access educational, financial, rehabilitation, compensation and other government services to facilitate sound transition planning. Regional ADF Transition Centres provide administrative management and support to members who are required to finalise their arrangements well before their date of separation from the ADF. (p. 18)
>
> …
>
> Services provided by the Directorate of National Programs in the Defence Community Organisation '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', including the 'Veterans and Veterans Families Counselling Service's Stepping Out program', which 'is available prior to separation', although attendance is also supported by DVA for up to 12 months post-separation. (p. 19)

Defence continues to improve the ways in which it supports its workforce, including in the key areas of stigma reduction strategies, preventative mental health and transition support. While there remains a group that continues to experience substantial negative effects of military-related reduced mental fitness, there remains a question as to whether the above solutions are the right ones, sufficient, and/or being delivered in a culturally appropriate way.

Defence is proactively attempting to respond to these challenges. In a subsequent section of this paper there are some more detailed observations on the level of preventative mental health care currently available. In an interview for this paper, a senior bureaucrat commented:

> While Defence has downsized its workforce by over 4,000 jobs over the last three years, none of the losses have been in the areas of social work or medical staff. It should be evident from a resource allocation point of view how seriously we take this issue.

Nevertheless, most acknowledge this is not an issue that can be wholly solved by resource allocation. The following quote from a PTSD-diagnosed veteran illustrates some perceived shortfalls in the mental health care currently available to serving Defence personnel. He describes the Post-Operational Psychological Screen (POPS) process that he underwent. The perceived absence of a sufficiently trained clinician (and particularly the description of 'young female' clinicians who soldiers wanted to impress), is not unusual and felt to be ineffective in achieving a therapeutic outcome. The description also highlights the 'tick and flick' approach to psychological support in the military and the way it serves organisational ends rather than providing actual psychological support for individuals:

> I do not believe they [issues described] were [addressed fairly]. All members, including myself, were given the green light upon returning to Australia after our tour to Afghanistan. I clearly remember all three of my screenings, two of which were with young females under the age of 25 with no history of deployment and after a few quick general questions I walked out the door after 10 minutes. I do not understand how I was so easily assessed and given back to the battalion. I had only just turned 19, shot through both thighs, nightmares each evening and total confusion from chronic nerve damage. I do not understand why critical questions aiming to discover depth within my mind were not drawn to the surface and assessed professionally. *(David—Appendix A)*

As noted, mental health in the ADF is a priority for the organisation as it is for government. It does however compete with mental health services to the broader community. While there are deficiencies in the policies and provision of mental health services to the ADF, an anonymous source interviewed for this research stated that they are significantly better developed compared with those available to the respective workforces of first responder organisations.

The following chapter will consider the background to research, planning and reviews in the recent history of the Department of Veterans' Affairs.

Department of Veterans' Affairs—policy background on mental health

Established in 1976 following the end of hostilities in Vietnam, the Department of Veterans' Affairs (DVA) has had to adapt to the changing profile of veterans—from a client base of First and Second World War veterans and their families, to veterans of Vietnam and the current generation of 'younger veterans' from the more recent conflicts in the Middle East and our own region, as well as a host of smaller groups. The client base now also includes another non-traditional client group—active service Australian Defence Force members who access DVA services through On Base Advisory Services (OBAS).

DVA is responsible for providing medical care, income support and compensation to serving Defence members, veterans and related communities, as well as their families. The Veterans' Affairs portfolio is administered by the Minister for Veterans' Affairs, currently a Victorian Liberal Party MP, Dan Tehan. The four key entities of the portfolio are:

- Department of Veterans' Affairs
- Military Rehabilitation and Compensation Commission
- Repatriation Commission
- Australian War Memorial

Supporting the work of the Commissions is the following list of additional entities:

- Office of Australian War Graves
- Repatriation Medical Authority
- Specialist Medical Review Council
- Defence Service Homes Insurance Scheme
- Veterans' Review Board

The Department of Veterans' Affairs is responsible for the administration of several key Commonwealth Acts which include:

- *Veterans Entitlements Act 1986* (VEA)
- *Military Rehabilitation and Compensation Act 2004* (MRCA)

- *Safety, Rehabilitation and Compensation Act 1988* (SRCA)
- *War Graves Act 1980*
- *Defence Service Homes Act 1918*

The *National Mental Health Strategy* 1992 (and subsequent iterations) was used as a foundation stone for DVA's mental health policy, as it was for the equivalent Defence mental health policy. As such, DVA sought to align its mental health policies and practices with those of the *National Mental Health Strategy*. This was reflected in the DVA publication *Towards Better Mental Health for the Veteran Community—Mental Health Policy and Strategic Directions 2001*.[75] As with the Defence equivalent, there was a lag of nine years between the national and departmental strategies. This document was designed as a guide for future planning and the provision of all mental health-related services to clients of DVA, and it emphasised the Department's stated commitment to 'integrated and community orientated mental health care'. The document contained four strategic directions:

- enabling a comprehensive approach to health care
- responding to specific mental health needs
- planning and purchasing effective services and
- strengthening partnerships and participation in mental health care (Towards Better Mental Health for the Veteran Community—Mental Health Policy and Strategic Directions 2001).[76]

This document drew upon published and available statistics on mental health that existed at the time. It acknowledged the detrimental effect that a mental illness has on the quality of life for veterans and that veterans experience prevalence rates for such illnesses at twice that of the general population. At the time, the DVA treatment population was 350,000, of whom 22 per cent (or 73,000) would receive some form of mental health treatment within any given year. The document also reported that psychiatric medication use was high amongst this population, with 20 per cent being prescribed one or more drugs. The number of accepted compensation claims for mental health-related reasons was also increasing and was averaging 25 per cent of the treatment population per annum (equivalent to 3,400 new cases every year). PTSD, and to a lesser extent, alcohol dependence, accounted for most of the increase. One in five veterans of the Vietnam War has been accepted as experiencing war-related PTSD.

At the time this document was published (2001), DVA was spending $190 million annually on compensation, treatment and support for veterans and their families affected by a mental health disorder. The document predicted that this was likely to increase in coming years for several reasons, including that mental health-related disabilities tended to be of a long-term nature and that there was a greater understanding of mental disorders and a greater willingness of those affected to seek recognition and treatment.[77] Finally, the document refers to DVA's *Strategic Direction for Health 1999–2007* which developed a 'more inclusive' understanding of health. Its emphasis included a 'more integrated' approach to health care, the provision of a greater range of choices, increased emphasis on 'preventative health', and partnerships with the veteran community to promote 'enhanced health'. Its broader aims included: a 'holistic approach to veteran care'; addressing identified issues in residential and community care; creating nationally consistent health services; and better integrating DVA's health arrangements with the Department of Defence.[78]

Pathways to Care in Veterans Recently Compensated for a Mental Health Condition (ACPMH—now Phoenix Australia)[79]

A report commissioned by DVA conducted by the Australian Centre for Post-traumatic Mental Health (now Phoenix Australia) entitled *Pathways to Care in Veterans Recently Compensated for a Mental Health Condition* was released in 2004. The study investigated how veterans recently compensated for a mental health condition accessed mental health care. The study concluded that compensated veterans have poorer health/quality of life than age-adjusted norms, despite the fact that around 90 per cent reported that their treatment had helped them. It stated that 43 per cent of participants in the study were not receiving treatment for the condition for which they had been compensated and 23 per cent had stopped their treatment altogether. The study recommended more research be done to explore the reasons for many of these issues.[80]

Independent Study into Suicide in the Ex-Service Community 2009[81] (DVA, conducted by Professor David Dunt)

This study points to the value of interventions such as clinician education (including in the detection and treatment of depression) and restrictions on access to firearms. It also highlights the importance of alerting general practitioners and other mental health workers to the increased risk of suicide amongst the veteran population.

This study picks up on the fact that while suicide rates are lower amongst serving military personnel than the general population, this is due to a 'healthy worker' selection effects and that this may fade over time. The study highlights the importance of transitioning members

feeling as if their service has been properly recognised by Defence and the problems that result when this does not occur.[82] This was a theme that arose in conversation with veterans during research for this paper.

One of the recommendations the study makes is to simplify the claims process and reduce the three military compensation schemes to one (p. 12—a proposal echoed by Senator Jacqui Lambie in an interview for this research). The study also recommended that DVA improve the communication process between its staff and clients who should rightly expect to be treated with respect and empathy; that there should continue to be a place for Ex-Service Organisations (ESOs) and that existing volunteer pension officers continue to play a role.[83] Furthermore, it was recommended that DVA should continue to improve the way in which it approaches 'hard-to-engage' clients (p. 15). The study also makes the observation that while DVA has been very active in supporting funding for research, it has been less active in supporting the evaluation of its programs.

Australian National Audit Office Audit Report: Administration of Mental Health Initiatives to Support Younger Veterans (DVA)[84]

The purpose of this 2011–12 audit report was to examine the effectiveness of DVA's administration of mental health programs and services in support of veterans of contemporary conflicts. In particular, it focused on the available programs of care and support in the context of mental health policy objectives to gauge if these programs met their objectives with regard to younger veterans.

The report noted that many younger veterans had served in numerous ADF deployments over the preceding decade and form a group which is particularly at risk of discharging from the military with an undiagnosed and untreated mental health condition. Further complicating the provision of health care to this group is that unlike previous generations of veterans, younger veterans do not necessarily maintain links with the ADF post-discharge or engage with DVA, nor are they easily contacted through Ex-Service Organisations.[85]

The review noted numerous studies commissioned by DVA into the scale of the problem and how best to meet the needs of younger veterans with mental health issues.[86] It noted that while attempts had been made to consolidate mental and social health efforts, the policy, programs, services and data systems continued to be managed across separate business areas. It highlighted the limited effectiveness of mental health initiatives, and gave examples of programs with a very poor take-up rate (examples cited included the Transition Management Service (TMS) and the *Stepping Out* program). Further examples are given where DVA has recognised problems and developed solutions, but failed to fully implement them. One such

example relates to the problem of tracking mental health care in transitioning members—a whole-of-life framework was developed, yet the report notes that the first steps of this framework were yet to be implemented five years after its launch.[87]

Strategy

A key planning document for the Department of Veterans' Affairs is its 2013 *Veteran Mental Health Strategy*.[88] This high-level planning document maps the department's intentions with regard to the mental health care of current and future veterans and their families. It is designed to provide a blueprint to guide the development of an action plan for the department's intended mental health services. The Strategy claims to provide the framework for a coordinated approach to the implementation and evaluation of existing programs, as well as planned new initiatives.[89] The Strategy balances the need to cater for veterans of previous conflicts as well as veterans from the more recent military campaigns in our region and the Middle East.

Australian Public Service Commission Review of DVA 2013[90]

Completed in December 2013, the Australian Public Service Commission (APSC) undertook a review of the organisational capability of the Department of Veterans' Affairs. The report states:

> It is evident to the review team that DVA staff are strongly committed to supporting the Australian veteran community. There is a palpable, sincere and passionate sense of mission among client-facing, administrative and policy staff within DVA; namely, to support those who serve, or have served, and to commemorate their sacrifice.
>
> The review team identified three key focus areas needing urgent attention for DVA to transform. They were:
>
> 1. operating structure, governance arrangements and information and communications technology (ICT);
> 2. approach to clients, culture and staffing;
> 3. efforts to formulate effective strategy, establish priorities and use feedback.

The report noted that whole-department improvements had been modest in preceding years and that major transformation was required. Organisation-wide cultural impediments also made sustaining motivation among DVA staff to support veterans, problematic. It noted that client service and acquiescence to every demand were distinctly separate issues. Also noted was that consistency and clarity around decision-making was just as important as a

commitment to client service; that priorities need to be set, particularly in the claims area where it quoted a staff member as saying that a claim 'is not seen as a person but an exercise in processing paper'.[91]

Samuel, quoted in Appendix A of this paper, echoed this point saying: '[DVA is] always busy and stretched. You are a number as more defence personnel are diagnosed'.

The report also noted that challenges persist for DVA in engaging with contemporary veterans who are not accessible in the way that previous generations of veterans were, and that this engagement was a key element in securing 'buy-in' from this new generation.[92] Anecdotally, many of the challenges highlighted above would appear to continue to inhibit the effective functioning of DVA, to the frustration of some clients. A senior member of the academic medical community commented in an interview that '[since this review], little has changed'.

In December 2013, the Minister for Veterans' Affairs, Michael Ronaldson, announced the release of the planning document *Towards 2020: a Blueprint for Veterans' Affairs*:

> 'The Secretary and I share a determination to ensure that the core strategy of the Department going forward is one that is fully client focussed, responsive and connected', Senator Ronaldson said.[93]

He went on to say:

> The main component of the plan is the Key Strategic matrix. This centres on the use of three key strategies—client-focused, responsive and connected—to describe the type of services we provide, and behaviours we need to embed across all areas of our business. These strategies should span across our work with clients, in developing and maintaining our culture and in shaping our organisation, and in doing so will help DVA to achieve our vision.

This is an example of the kind of rhetoric employed by DVA to counter some of the above criticisms. Another was the often repeated 'four pillar approach', as described here in a statement by Minister Ronaldson:

> At the last election, the Government announced a comprehensive policy agenda to meeting the needs of veterans and their families. We announced our four-pillar approach to veterans' affairs:

- Recognising the unique nature of military service;

- Retaining a stand-alone Department of Veterans' Affairs;
- *Tackling the mental health challenges for veterans and their families; and*
- Supporting veterans through adequate advocacy and welfare services.[94] *(emphasis added)*

Mental health features prominently in various research projects undertaken by DVA and is a particular focus of the current project *Transition and Wellbeing Research Program.* Launched in July 2014, the focus of this research is the mental and physical health of service personnel after discharge, and how symptoms change over time.

Department of Veterans' Affairs Annual Report 2013–14[95]

The 2013–14 annual report affirms the department's stated commitment to mental health as a priority area of attention for the coming year. The report cites the *Veteran Mental Health Strategy—a Ten Year Framework 2013–2023* as the source document for much of the department's thinking around mental health issues. It includes reference to a new 'strategic model' which aims to generate 'best practice research' in support of mental health care. It also discusses its collaborative research efforts with the Department of Defence as well as research institutions.[96]

The Prime Ministerial Advisory Council on Veterans' Mental Health (PMAC) is a new initiative launched in 2014 by the current government and administered by DVA.[97] It forms another part of the way in which the department approaches the issue of mental health and its client base. A senior health professional who agreed to be cited in this report on the condition of anonymity criticised the PMAC for the lack of representation on its board of independent health professionals. This deficiency is broader than the PMAC and has been noted (same source) as applying to the field more generally. Some health professionals working in veterans medical research and practice feel (none agreed to be identified) that the opportunities to contribute in a meaningful sense are limited, and that consultative and advisory forums dominated by bureaucrats do not make best use of specialist medical expertise.

A key feature of the mental health-related activities during 2013–14 on which the department reported was the range of online education and self-assessment tools. Issues targeted included veteran suicide; alcohol consumption; access to research findings; and tools to assist practitioners in managing complex cases. Communication tools utilised as part of these initiatives included website development, smart phone apps and YouTube. The report also

contains reference to the $26.4 million allocated in the Budget to strengthen its commitment to veterans' mental health and corresponding initiatives.

Department of Veterans' Affairs Annual Report 2014–15[98]

Under the heading of 'mental health' DVA's 2014–15 annual report states the following:

> During 2014–15, the Department's efforts in mental health were focused on early intervention, to improve the longer term prospects of veterans' recovery from mental illness. Activities included:

- promoting mental health and wellbeing through DVA's mental health online portal, *At Ease*;
- implementing ways to make it easier to access mental health treatment through DVA's Non-Liability Health Care arrangements;
- expanding eligibility under the VVCS; and
- reducing the time taken to process compensation claims.

It also appears to be placing more emphasis on homeless veterans and the provision of services and support to this group. Suicide prevention is another area of focus for the department identified in this document.

DVA submission to the recent Senate inquiry

In June 2015 DVA made a 54-page submission to the recently completed Senate inquiry entitled *The Mental Health of Australian Defence Force (ADF) Personnel who have Returned from Combat, Peacekeeping or other Deployment.*[99] The document provides some comprehensive information about DVA's contemporary approach to mental health.

Despite the comprehensive information available in this submission and the numerous programs offered by DVA, a persistent criticism of the department raised during interviews for this paper was the apparent lack of strategy to develop and sustain expertise in the area of veterans' mental health (the source chose to remain anonymous). DVA makes the assumption that this expertise will exist within the broader health system and be available for purchase. While there have been some moves towards sustaining this resource through Phoenix Australia, the department has, to some extent, divested itself of the responsibility for fostering future clinical research expertise (same source). A further observation made by this source was that the number of experts within the ranks of the department has decreased with its

downsizing. This has led to an increased reliance on bureaucratic solutions to complex problems rather than being guided by professionally-led change. The theme emerged during conversations with professionals working in this space that a disconnect exists between Defence and DVA. This will be explored further in the following sections of this report.

The following two excerpts from veterans interviewed for this research illustrate the frustrations felt by some veterans with the apparent inconsistency between the recognition of issues by one bureaucratic organisation and not another. Harry said:

> Since my discharge from Defence I have had a lot of frustration with my transition to DVA. What was allowed and proved to be a need in Defence, needed to be proven again and reasons for it [provided] to DVA. There is no link between the two, creating stress to families and individuals. *(Harry—Appendix A)*

Gary expressed similar sentiments:

> As for my compensation claim, I was medical 401 discharged due to an injury I sustained while on SAS selection in Perth; the compensation board denied liability for five long years. How can you deny liability for an injury that was sustained on a course for work which the Army then sacked me for? *(Gary—Appendix A)*

Care needs to be taken not to confuse a DVA client not getting what they want, with larger systemic problems. The focus here is on the ways in which the provision of services and support can be strengthened. Part of identifying where problems exist is listening to the experiences of those who have been through the system. Once again, care needs to be exercised in generalising from the experience of the very small number of veterans who participated in this research. What is being suggested is that experiences such as those cited above, combined with the testimony of working professionals, can point to areas where sustained research might usefully be focused. There is also a shared feeling that complaints are not listened to and are therefore not worth making:

> Since discharge I have had no ongoing relationship with Defence. Contact with DVA is extremely frustrating. You ring up for help and get told to refer to their website. The whole process is very complicated and without the hard work done by advocates the claim process would have no chance of success as you do not have access to the relevant legislation and DVA's statement of principles regarding different types of injuries. DVA often sends out the wrong paperwork. I have been accused by DVA of not attending medical appointments and/or not sending paperwork back in. I have been spoken to like I am a complete moron, with utter disregard and contempt. You are made to feel like you are another whinging serviceman out to defraud the system, or a complete bludger who has just suddenly decided to quit work and live off the system.

> Several of my veteran friends have even gone as far as to lodge official complaints against the person from DVA who they were speaking to because of the accusations and degrading and insulting manner in which they are being spoken to. You get the feeling that DVA makes the whole process so complicated and drawn out that you will give up out of sheer frustration. In regards to being treated fairly, it is my opinion that DVA looks for the easy option that will save the department money. No regard for the veteran's personal and family life is taken into account. The stress of the whole process from start to finish is extremely taxing on both the veteran and their family. Often, the easy option taken by DVA results in the veteran and their advocate having to take DVA's findings and decisions to the Veterans Review Board for appeals, and the veteran being admitted to a psych hospital for further review and also to prove to DVA that your PTSD is real. The cost of this to DVA must be substantial and it seems the only party to benefit from this is the private hospital. During the veteran's stay in hospital he may be heavily sedated to alleviate the symptoms of PTSD brought on by the bureaucratic red tape.
>
> I understand the need for checks to ensure that people are not defrauding the system, but … you spend countless hours in psychiatrists' offices reliving the events on operations that lead to PTSD, and with your wife/partner telling the psych the effect of PTSD on the family and in social interactions, and [there is] the physical pain that you live with daily due to soft tissue injuries you sustained during your service, the hearing loss and tinnitus from small arms rifles, the news that one of your mates that you served with has taken his life as he felt that was the last option because a person in DVA decides that he isn't worth a full pension and only receives $900 per month despite the medical reports saying he will require ongoing medical treatment. *(Walter—Appendix A)*

For more information on the relationship between DVA and Defence, including arrangements for the transfer of responsibility between departments when an ADF member is discharged, see the explanation of the Memorandum of Understanding on the DVA website.[100]

2014–15 Department of Veterans' Affairs Budget Fact Sheet[101]

According to its 2014–15 Budget Fact Sheet, DVA received $12.3 billion for veterans, and supports around 310,000 veterans and dependents. 'This funding includes $6.7 billion for income support and compensation pensions and $5.5 billion for health services', including mental health services.

Image problem

While much good work is recorded in the above chronology of the department's evolving approach to the (mental) wellbeing of its client pool, it is common to hear veterans (both of Vietnam and more recent conflicts) talk of their extreme frustration with the department. This

sentiment is echoed by working professionals and acknowledged during interviews for this research by a number of senior DVA officers. While there is strong criticism of available programs, the lack of evidence around what constitutes best-practice is limited, leaving the department in a very difficult position. Should an evidence base for best practice service provision not exist, DVA can hardly be criticised for not implementing it. The (negative) image of DVA is a significant and perennial problem for the department. While numerous DVA publications communicate the department's efforts to address the root causes of its image problem (see, for example, the DVA submission to the Senate Committee, *The Mental Health of Australian Defence Force members and veterans*), as long as there are military personnel negatively affected by their service, DVA's image problem may be unsolvable.[102] as long as there are military personnel negatively affected by their service, DVA's image problem may be unsolvable.

PART III—MEASURING PROGRESS

The third part of this monograph describes areas of significant progress, both in better informed attitudes and the provision of services and support, and other areas where progress is required. The persistent issue of stigma acts as a reminder of the low starting point of knowledge and uninformed attitudes towards service-related psychological injuries. A hopeful note is struck by the 2nd Commando Regiment and its approach to dealing with the health and wellbeing of its workforce. The changing attitudes of veterans have a shaping effect on broader attitudes towards service-related non-physical injuries. These pages record some attitudes that focus on the invaluable range of services and support available to veterans. Other veterans' attitudes appear to remain trapped in an entitlement mentality that sees DVA as the enemy with whom they must wage battles for compensation. Finally, the issue of preventative mental fitness will be introduced, investment in which is seen to have good prospects for improved outcomes. Ultimately, society has come a long way from a very low starting point. However, as this report demonstrates, the results are not yet entirely effective and without significant investment in this issue now, there is the risk that the mistakes of the Vietnam War will be replicated, creating another long legacy of psychological injury from recent and current deployments.

Stigma

The issue of a pervasive stigma surrounding mental health was raised in a number of the interviews done for this research, by politicians, psychiatrists, senior military leaders and veterans.[103] The impacts of stigma associated with the mental health of civilian populations are well-understood by these groups.[104] Much work has also been done on the stigma of mental illness in a military context and on how mental health stigma in a civilian setting relates to stigma in a military setting.[105] An influential early voice on the study of stigma, Erving Goffman, described it as a sign of disgrace setting a person apart from others, often resulting in those affected delaying seeking help or denying their symptoms altogether until the point of crisis.[106] Both a lack of factual information and strong negative emotional reactions to reduced mental fitness are at play in the original data that follows. People find symptoms of psychopathology threatening and the discomfort that other people feel fosters stigma and discriminatory attitudes towards those who admit to experiencing problems.

> I used to think—'that weak cu*t, what has he seen that I haven't seen?' Until I got it myself and then I understood, it doesn't mean you're weak, it's an injury. *(veteran S)*

> Everyone knows that you get PTSD and your career is over. *(veteran R)*

> Personally it was a difficult time as I didn't really have any answers why I was depressed and I couldn't attribute it to any one incident. It was confusing and embarrassing as I had no control of my emotions and could not trust myself to keep it all in check. Initially it was something I tried to hide, but it got to a stage where I was totally useless and couldn't concentrate on anything except trying to hide my condition. *(John—Appendix A)*

Left untreated, psychological injuries and reduced mental fitness can have wide-reaching negative impacts on personal wellbeing. It touches every aspect of a person's life, including their social and emotional wellbeing, as well as their cognitive functioning. In an interview for this research, psychiatrist and specialist in veterans' health, Dr Andrew Khoo, stated his belief that the stigma surrounding mental health in the ADF is our biggest challenge and that the single biggest difference that could be made to mental health outcomes in military personnel would be to identify unwell individuals earlier and then maintain them in effective treatments. Dr Khoo believes that dealing with stigma is a more urgent issue than even treatment development. In a culture that lauds strength and shuns weakness, the cultural change necessary to convince serving personnel to seek help is significant (Senator Linda Reynolds).

A culture that values strength and preparedness to help others before oneself (qualities that make a good soldier) leaves Defence personnel and veterans vulnerable to a reluctance to seek treatment for symptoms of psychological injuries when they occur. Coupled with a culture that views such injuries as weakness and tantamount to malingering, the landscape of stigma and mental health in Defence, becomes, for some, a cultural norm that will never be resolved (Dr Graeme Killer, DVA Principal Medical Adviser):

> I've heard WO1s call blokes who are genuinely injured 'lingers' [malingerers] on more than one occasion—disparaging at best and downright contemptible in light of genuine illness and injury. *(Sara—Appendix A)*

Further complicating the issue is that a diagnosis of a psychological injury is often thought to lead to missed deployments and promotion windows, and result in involuntary discharge on medical grounds. This, combined with the fact that such injuries can be hidden, means Defence has a negative attitudinal culture around mental health that may result in large numbers of psychologically injured personnel not receiving treatment. While no one is arguing that those with reduced mental fitness require support and/or treatment as a priority over career considerations, it is widely acknowledged by working professionals both within and outside the ADF, that the stigma of mental illness is a significant additional barrier to an ADF career than a medical issue alone. The lack of recorded evidence of mental illness can result in delays in recognition by DVA in the future (Dan Pronk, former ADF Regimental

Medical Officer). This has led to Veteran D, already chronically unwell, becoming re-traumatised as he attempted to establish the basis of his claims later—'You don't say anything until you get out, then [you're] accused of pension chasing' (veteran D). Increased awareness that war can have negative psychological effects and that this constitutes an entirely normal human reaction, normalises psychological injury which is an important part of this puzzle (Peter Leahy, Chairman, Soldier On). Sometimes a formal diagnosis can be unhelpful, stigmatising and making the situation worse:

> Fifty years ago Michel Foucault drew attention to the medicalising of social problems; in looking at the deployed experience of uniformed men and women, we need to avoid psychologizing what may be moral problems.[107]

Suggested solutions include the need for highly-targeted stigma reduction measures (Nicole Sadler, Defence psychologist; comments in an interview for this research) because a message that reaches one target group will be ineffective with other groups. Frank Quinlan (Mental Health Australia CEO; in an interview for this research) suggested that the issue of stigma should be turned on its head. At present, those experiencing reduced mental fitness are made to feel ashamed of their situation. Instead, there is a need to replace stigma with a narrative that is unwilling to accept discrimination of those affected by injuries of this kind—'We should be focused on an organisational discourse of genuine care and support that can equip soldiers and their commanders to layer culturally appropriate models in their own units, coupled with expert care' (Paul Dabovich, researcher, University of Adelaide). This kind of change is unlikely to organically occur from within Defence and will require political intervention (Melissa Parke MP, ALP Fremantle).

Dr Andrew Khoo stated in an interview for this research that one of the most important things that will convince serving Defence personnel to seek treatment for mental health-related issues is to see others do it, resolve the issue with treatment and successfully return to work. In this view, this will begin to foster a justified belief that mental injuries will be treated like physical ones. Additionally, while some mental injuries, like physical ones, will not be successfully treated and result in a return to work, if others see resources and support being made available to those affected, stigma will be further eroded. The recounting of personal experiences by credible sources who overlap with the target group and who have themselves experienced reduced mental fitness, may be one strategy to assist in the erosion of stigma. The point is that rather than proselytising, these personnel instead provide the opportunity to learn from the experiences of those who have been through a successful rehabilitation program.

Soldiers sometimes seek to disguise the truth to achieve their desired outcome. Examples range from 15-year-olds forging birth certificates to join the Australian Imperial Force (AIF) in 1915 to soldiers disguising mental and physical injuries to avoid the unpleasant social and professional consequences of acknowledging them. Creating clarity around this may encourage dialogue around harm minimisation and improved strategies when a soldier's career comes to an end (interview with Paula Dabovich).

One interviewee, John, remarked:

> When I was diagnosed as having depression and anxiety issues, I was effectively downgraded medically. The period of MEC [Medical Employment Classification] downgrade was approximately 12 months, during which time I was not eligible to participate in any courses, exercises, training, weapon handling, driving of a military vehicle, etc. At certain ranks and windows in a soldier's career you only have limited opportunity to be considered for promotion or attendance on promotion and career advancement courses. If you are ineligible for these activities due to being MEC downgraded, you essentially miss the window and that opportunity has flow-on effects for the remainder of your career. For example, DSCMA [Directorate Soldier Career Management Agency] will compare you against your peers for such things as promotion by looking at everyone's annual PARs [Performance Appraisal Reports] over a period of 3–5 yrs. If you have been unable to participate in all activities and exercises, then your annual PAR will reflect this and you are no longer going to be competitive with your peers for promotion, courses or certain jobs. *(John—Appendix A)*

While a psychological injury may mean that an individual is no longer able to perform their duties until they recover fully, much like the impact of a physical injury, it is the additional element of stigma that accompanies a psychological injury which amplifies the impact beyond a medical issue. The following comments from David (see Appendix A) illustrate the manner in which reduced mental fitness can be mistaken for a disciplinary problem (and dealt with using bastardisation):

> If you went to the padre or psych, [you were seen as], for lack of a better word, [a] 'poofter, faggot or weak cu*t'; sorry for the use of this language but to understand how demoralising it was for some soldiers, these words must be used. It started from higher ranks such as a Sergeant or Corporal and as you could imagine, it only manifested tenfold amongst the diggers. I clearly remember one soldier who was thrown into a cage, locked in there like an animal, a cold bucket of water tossed in and broomsticks poked through the gaps. This is a severe case but stands true. He was later psychologically discharged from the Army. Of course that's not fair. This was not uncommon and rank just turned a blind eye or walked out of the room when this behaviour was developing. A friend recently told me that he believes some of the courageous men he served with, were

> the diggers that copped sh*t every single day of their service. They were belittled, demoralised, but yet they continued to stand by their mates and serve their duty. *(David—Appendix A)*

Susan's comments below illustrate the urgent need to normalise discussion and treatment of those diagnosed with a psychological injury:

> One of the biggest issues that I faced in Defence was management, particularly middle management, not knowing how to handle or deal with mental illness. The truth is it should be dealt with no differently than any other injury. Management level Corporal through to Major need to make it 'ok' to talk about mental health. It's all well and good having processes in place but most of these processes make people requiring them feel like they are only to be used if you are struggling or can't handle it. Programs and support should be a continued 'wellbeing approach'. Like a BFA [Basic Fitness Assessment] or a peer review. It's just something that happens. It should just become so normal that no one even thinks twice about it. Going to war is not normal—seeking support for it is!! It is for this reason that there needs to be more open communication about PTSD and mental health in my opinion, to encourage people to talk openly about it. Make it normal 'morno' talk, not a slide show every twelve months. It needs to be personal and it needs to be real. *(Susan—Appendix A)*

The comments below illustrate the shame still attached to psychological injuries, which is reflected in the attitude that it is better to hide the problem than allow others to think you are 'nuts':

> I have kept my PTSD and Chronic Depressive Disorder very quiet, so at this stage it has had minimal effect on my work life; I do find that I have time off on occasion due to 'not feeling quite right', but at this stage my employer is kept very much in the dark and I deal with my issues at home. Well it's not really fair, but I also don't want my employer and my work mates thinking that I'm nuts. *(Gary—Appendix A)*

While mental fitness issues can be hidden or disguised as something else, it is also the case that other kinds of (physical) medical conditions may be kept from employers for career reasons.

Ex-Service Organisations

A key feature of the service model as it currently exists is the collection of ESOs that have grown to fill the (perceived) void between services and support provided by Defence and those provided by DVA. These pages record examples of ESOs that provide an invaluable range of services and support to veterans. There is, however, a feeling (expressed by a

number of interviewees for this research who prefer not to be linked to these comments) that some advocacy and support groups appear to remain trapped in an entitlement mentality that sees DVA as the enemy with whom they must wage battles for compensation. These groups are often protective of their own organisation and wary of cooperation with others. It has been noted that failure on the part of the RSL, as the premier and iconic representative group, to keep pace with the changing needs of younger veterans has contributed to the proliferation of newer and smaller organisations.[108]

As discussed in a previous section of this paper, while many interviewees acknowledge the useful role played by ESOs in plugging gaps between Defence and DVA, and providing care and support to veterans, problems (including the above-cited entitlement mentality) do exist in the current model. While a small number of such organisations have been around for decades (RSL and Legacy are the examples most people are familiar with), many smaller organisations have sprung up during times of need, then disappear. A Queensland sub-branch of the RSL has counted 80 such organisations in Queensland alone.[109] Currently, Mates for Mates and Soldier On are seen by a number of interviewees to be more responsive to the changing needs of veterans than the older organisations.

The manner in which ESOs compete for attention, public donations and government funding; the overlap and redundancy in the services they provide; and the (at times bitter) in-fighting and disagreement that occurs between the groups themselves are some of the problems that currently exist. Among the consequences of this is a diluting effect on the power of these organisations. While one compellingly expressed coherent message may find traction, empathy fatigue can be an issue when there are a number of competing voices. Some have also been noted (by sources who chose to remain anonymous) to foster an entitlement mentality and become fixated on winning DVA compensation for their members and 'going for gold' (securing DVA Gold Cards for veterans).

Stories related during interviews for this research include groups that celebrate every time a member receives a Gold Card as a win against DVA, and other groups that guarantee a 'TPI' (Totally and Permanently Incapacitated) classification if clients use their recommended form of words in a DVA application. For some, winning a benefit has become an end in itself. The emphasis on these 'battles', the entitlement mentality and belief that everything is compensatable, and the extent to which the current system is open to abuse and exploited by some groups, are among the observations made during interviews about the current system of ESOs. Notwithstanding these issues, a large number of veterans and others work (often unpaid) for the welfare of Australia's ex-service men and women. The Chief of the Defence Force (CDF) believes that the ADF can play a useful coordination role with respect to ESOs

(Mark Binskin—CDF). Some form of centralised administration may alleviate some of the chaos that currently exists. A coordination role that focuses efforts where they are most needed and eliminates duplication may make a positive difference to this sector.

Another suggestion that has been made is that such organisations should actively attempt to include all veterans in activities, not just the wounded, injured or ill (Gus Gilmore—military officer). A diverse community is much better able to help a minority of those adversely affected people than if those few who experience reduced mental fitness are forced to try and help themselves in the absence of the support of empathetic veterans.

Reported experiences of members of the 2nd Commando Regiment—a case study

An encouraging note is the work being done by the 2nd Commando Regiment and the comparatively mature approach it takes to the mental fitness of its workforce. There are elements of this that provide an example of what can be done. This Regiment has achieved much-improved outcomes for its members. It has been successful at substantially reducing the stigma around reduced mental fitness and has offered substantial support to transitioning members in a culturally appropriate way.

One feature of debates around mental fitness and the military that often goes unreported is those commanders who are well-informed on mental fitness and related issues, and who genuinely care about the individual welfare of soldiers under their command and are able to communicate that to them. Numerous examples of this became apparent while completing this research. Air Chief Marshall Mark Binskin, Lieutenant General Angus Campbell, Lieutenant Colonel Ian Langford and Major General Jeffrey Sengelman all ‘get it’, as does (Wing Commander) Joanna Elkington who described her entire remit as CO as genuinely caring about her people and personally concerning herself with their welfare. Sources of information for this section include current serving members and senior leadership including the CO (with protected identities), a former 4RAR (now the 2nd Commando Regiment) Regimental Psychologist (Clint Marlborough), independent research conducted by journalist Chris Masters, and doctoral research by Paula Dabovich.

The view in the 2nd Commando Regiment is that each individual soldier represents such a significant capability that, should that capability be reduced for any (preventable) reason (including mental fitness), it should be identified as quickly as possible, resources marshalled, and appropriate care and support given to get that individual (capability) back working as soon as possible. One of the strategies used for achieving this end is the Human Performance Wing (HPW). Extracts of the *Human Performance Handbook: a Guide for Commandos by Commandos*, developed within the HPW, were obtained for this report (the

document as a whole is restricted to internal regimental use only). The handbook states the following:

> The Human Performance Wing (HPW) was established in 2013 as a soldier led, academically informed and command supported initiative to provide culturally appropriate support to seriously wounded, injured and ill commandos. HPW is an intermediate space where soldiers are supported during times of significant change, as they work to establish and achieve their goals and update their identity.
>
> The aim of 2nd Commando Regiment's HPW is to provide culturally relevant, non-clinical holistic care to members who are undergoing rehabilitation. HPW also facilitates personal development using human performance optimisation principals to enhance individual wellbeing and collective capability as well as providing the opportunity for those transitioning from the regiment to do so with a strong personal foundation and dignity.[110]

From a number of accounts, this is an individually focused support network that treats mental fitness in a similar way to physical fitness. It takes a mature and considered approach, often involving support personnel who have experienced the negative impacts of psychological injury themselves, with an emphasis on recovery and returning to work as soon as and wherever possible. Part of the philosophy of the HPW is to look at a 'state of battle readiness' as a continuum along which all soldiers operate, and that an individual temporarily posted to the HPW is simply on another point in that continuum. A current serving member of 2nd Commando Regiment commented during an interview for this research that 'the HPW is genuinely good; look at 2nd Commando Regiment as an example of what is working well' (veteran S).

Clint Marlborough (former military psychologist) commented during interview that 2nd Commando Regiment treats mental health like physical health; it makes a big investment in people, understanding that they will get hurt, and wanting to treat any mental/physical injuries and get them going again. Another current serving member of 2nd Commando Regiment commented that in his 15 years in the Army he had not been given any mind-related training until being posted to 2nd Commando Regiment where the CO encouraged his workforce to engage with the *Redesign My Brain* TV series. Paula Dabovich made the comment that the 2nd Commando Regiment has a capacity-building framework that focuses on high-end and optimised performance, and which seeks to build upon strengths regardless of very real and often serious physical, psychological or battlespace limitations. She said it focuses on growth, rather than disability.

'Big Army' (the Australian Regular Army) has Soldier Recovery Centres (SRCs) which at first glance look like the 2nd Commando Regiment model of High Performance Wing. However, it was described during interviews for this research as being outside the unit's chain of command, and while the HPW is about individual results and outcomes, the SRCs become dumping grounds for unwanted and discharging soldiers. The SRCs are often staffed by NCOs and commanders who have no experience with mental fitness issues, therefore furthering the opportunities for misunderstandings and stigma to flourish. Staff equipped with maturity, compassion and wisdom have the ability to provide the level of non-clinical support genuinely required in this area. David Dunt (professor, University of Melbourne) commented during an interview for this research that the SRCs have not been rolled out well. A senior commander of 2nd Commando Regiment stated in interview that 'while 2nd Commando Regiment is doing mental health well, it's an indictment on the ADF, not a positive for 2 Commando' (protected identity).

However, translating 2nd Commando Regiment's HPW to 'Big Army' is not quite so simple (Senior Commander). This commander went on to say that 'Big Army' first has to define the problem before they can attempt to begin dealing with issues of mental fitness. A former 4RAR psychologist related a story during interview that the day he marched into the Regiment, the CO asked him 'why the fu*k are you here? What am I supposed to do with you?', in genuine bewilderment at the presence of a psychologist in his regiment. By the end of his posting to 4RAR, SOCAUST (Special Operations Commander Australia) presented him with an award recognising the contribution he had made to the Regiment (Clint Marlborough). This is a powerful illustration of the change in attitude and the power of having the right person for the job.

While the Special Air Services Regiment also invests heavily in the training and support given to each of its operators and achieved similar success to that described above, it was Chris Masters' impression that the 'brotherhood' model of 2nd Commando Regiment means its members enjoy better mental health support than their SASR colleagues with their 'lone wolf' reputation.[111]

It is noted that while the time devoted to mental fitness in the Australian Regular Army, Navy and Airforce is felt by some to be inadequate, it is one of a number of competing priorities, particularly in busy operational units. As this report demonstrates, however, it is a priority that is critical to preventing the sorts of issues discussed above from flourishing.

Prevention

Mental health promotion is any action which maximises mental health and wellbeing. Prevention is defined as interventions that occur before the initial onset of a disorder to prevent the development of the disorder. Prevention relies on reducing the risk factors for mental disorder, as well as enhancing the protective factors that promote mental health. Universal interventions are aimed at improving the overall mental health of a population: an example would be programs aimed at building mental health literacy across all personnel in all services as part of an integrated mental health awareness-raising process (Kerry Howard).

As stated, a key challenge presented by the issue of mental health and Defence is the need to find a circuit breaker to the circular argument that sees 'broken' veterans doing battle with DVA. As suggested, a change in narrative to one focused on health, rather than illness, might go some way to achieving this end. This preventative approach might be underpinned by an increased focus on such things as:

- raising mental health literacy/awareness
- mental health first aid and
- increasing the evidence base for best-practice preventative models.

This may not only reduce the rates and fall-out of reduced mental fitness, but potentially result in a reduction in treatment and compensation expenditure. The change in mindset in getting everyone involved in activities of this kind, not just the 'sick', may also make significant headway in decreasing the stigma that surrounds reduced mental fitness.

The recently released *National Review of Mental Health Programmes and Services*, completed by the National Mental Health Commission under the heading 'Future Approaches and Funding Priorities', makes the point that the re-allocation of resources to 'upstream services' such as prevention, can achieve value for taxpayers' dollars.[112] For example, the Review identifies measures to help the Commonwealth maximise value for taxpayers' dollars by using its resources as incentives to achieve desirable and measurable results, and funding outcomes rather than activity. It also proposes re-allocating funding from *downstream* to *upstream* services, including prevention and early intervention. Evidence exists for the economic benefits of a preventative approach to mental health.[113]

The World Health Organization (WHO) report *Prevention of Mental Disorders—Effective Interventions and Policy Options* describes prevention as one of the most obvious ways to alleviate the burdens related to 'mental disorders'.[114] According to the report, mental

disorders are linked to human rights issues which demonstrates how pervasive the effects of stigma, discrimination and human rights violations are. It is (wrongly) believed that no effective treatment modalities exist. Preventative strategies can therefore not only impact the wellbeing of those affected, but also combat the stigma associated with 'disorders' of this kind.

In its submission to the recently completed Senate inquiry into the mental health of the ADF, the national branch of the RSL labelled the 'significant lack of access to services involving both prevention and care' as 'unsatisfactory'.[115]

Defence has a number of programs in place that incorporate elements of preventative mental health approaches. Examples include the 'battle smart' program (that may include a single two hour presentation delivered to a soldier); suicide prevention presentations as part of yearly top-up training; the Veterans and Veterans' Families Counselling Service (VVCS); and 'Mental Health Day' activities.[116] However, these programs represent an ad hoc approach to preventative mental health care (anonymous). Where best-practice and culturally appropriate prevention strategies do not exist, making them research priorities will help close this gap in the literature and improve service provision. The application of such knowledge to the normal operating practices of the ADF may result in significant increases to the wellbeing of the workforce, as well as financial benefits for government. DVA's allocation of resources for health treatment is around $5.5 billion annually, of which only around $200 million is allocated for mental health services. However, investment in preventative mental health represents only a fraction of this $200 million.[117]

For a workforce that receives state-of-the-art training in so much of what it does, is highly proficient in the art of conducting warfare, and is a profession that routinely exposes its people to traumatic events, the absence of a well-defined pro-active and preventative program of mental health conditioning would seem to be a significant deficiency. There appears to be little evidence of substantial preventative mental health measures being put in place and routinely used to good effect. While some preventative services do exist, little is known about the way in which the target groups access these services or how effective the services are at combating rates of reduced mental fitness.

Resilience is a topic that Defence believes is important to its work. If Defence can train resilient and well-prepared soldiers, they will fight better and be better prepared when they come home. As a senior commander said:

> Firstly, I believe the weight of resources should rest with developing individual and group resilience rather than management. I believe it is important to include group

resilience in any consideration of mental health. The military, particularly the Army, relies on complex social bonds that we have not fully mapped and rarely acknowledge. In my experience the resilience of strong teams has a direct relationship with the resilience of individuals within those teams. I have a feeling that the strength of the leadership of these teams also has a strong bearing on the resilience of the individuals. For example, there is a contemporary Australian Infantry battalion that adopted some very overt branding, language and labelling relating to 'brothers in arms', 'unbreakable bonds' etc.; however, the leadership was brittle and the unit would appear to have experienced quite a large number of mental health challenges subsequent to their deployment. The group resilience was poor and lacked substance, and individuals were not well prepared as a result. This is anecdotal of course. The point is that group resilience is critically important and must have substance and depth. It needs the depth of real and genuine investment, not matching sleeve tattoos and t-shirts bearing mythological Greek iconography.

Turning to individual resilience, I believe tough, challenging and realistic training has a significant influence on the development of individual mental resilience. As a Squadron Commander I used to demand that we train to failure. Obviously we also trained to win because that promoted confidence, but that came later. For a great deal of our pre-deployment training prior to Afghanistan we threw ourselves into complex and chaotic training serials and did our best to turn ourselves inside out. The debriefs went longer than the orders and we were extremely hard on ourselves. We would regularly bring in external 'assessors' to evaluate us and break any 'group think' that was developing. We stressed the importance of excellence in everything that we did, we demanded honesty when we collectively failed and we pushed ourselves to breaking point at times. This was done carefully and deliberately, and with a specific objective in mind. The objective was to harden us individually and collectively.

Individual resilience comes from knowing that one particular 'hard moment' is no harder than others you might have been in before. Tough training is the best way of ensuring that the 'hard moment' during a deployment can be placed within a context of 'other hard moments'.

So, in my view, individual and group resilience is key to strong mental health. *(senior commander, protected identity)*

…

Walk soldiers up to trauma—give them their worst day in training not in the field—this is a key to well-prepared soldiers. *(senior military commander)*

The above sentiments on resilience reflect the experience of highly-regarded military leaders. As the evidence-base around the idea of resilience is lacking, effort could usefully be spent in bridging this evidence gap. Care does need to be taken to ensure that individuals are not left with the impression that illness reflects a lack of resilience and is therefore their fault. It is important that we do not throw the problem back on individuals, rather than holding to account the system that routinely exposes its personnel to trauma. In addition to resilience, there is an urgent need for an increased focus on other forms of psychological preventative measures and increased mental health literacy (David Dunt).

Currently, there exists a need to go beyond the focus in the military on 'resilience' to other preventative approaches. Prevention and resilience are not synonymous. A focus on resilience is a double-edged sword. While it may better prepare a soldier (sailor or airman) for duty (and by extension, life after the military) it may also, inadvertently, set them up for failure. If a defence member becomes unwell, it may further entrench stigmatised attitudes if they are seen to lack resilience, or made to feel that it is something they should just be able to overcome. As well as contributing to an increase in wellbeing, a change in preventative approaches is also likely to have economic benefits for government. There exists scope to apply preventative mental health approaches from civilian to military settings. As this is a complex issue, a systematic study of it is beyond the scope of this chapter; the aim instead is to highlight this as an issue where effort could helpfully be applied in the ADF.

> We need to be saying to commanders, this is what you can do to improve the mental health literacy of your workforce because they care about their men: we need to be setting up efficient return-to-work policies; spend money on IT, the Web and future education packages; and identify the best points of access … the CDF gets it, but everyone needs to 'get it' and that comes through education. (Dr Andrew Khoo)

A psychologist with a professional interest in veterans' mental health commented during research for this paper:

> Currently there is a huge cost of treating PTSD and this is unnecessary. Prevention and mandatory psychological training and treatment should be implemented. PTSD and other psychological injuries are curable with treatments such as EMDR therapy [eye movement desensitisation and reprocessing] and the member may become deployable again. Elements of these treatment options could be included in the existing Battle Smart training. (Kerry Howard)

Another proposed treatment model relates to an increased use of training in mental health support. 'The military could train more military personnel in accredited mental health support' (Frank Quinlan). Despite attempts to increase the mental health literacy amongst the

general population, it remains low and this is reflected in the ADF (source chose to remain anonymous). A key observation of this monograph is that there could be considerably greater focus on prevention. This is a view echoed in the American context, as described in the report *Preventing Psychological Disorders in Service Members and their Families: an Assessment of Programs*:[118]

> Recommendation 1: The committee recommends that the DOD employ only evidence-based resilience, prevention, and reintegration programs and policies and that it eliminate non-evidence-based programming. Where programming needs exist and the evidence base is insufficient, DOD should use rigorous methods to develop, test, monitor, and evaluate new programming.

The report highlights the lack of an evidence-base for many of the 94 identified programs that specifically address prevention on the resilience, prevention and treatment continuum. The knowledge gap in the evidence for preventative mental health approaches is one that needs to be filled so that it can become a part of 'business as usual' for the ADF.

International and Australian approaches to PTSD

In 2013 the Royal Australian and New Zealand College of Psychiatrists (RANZCP) conducted a review of prominent internationally recognised clinical guidelines for the treatment of PTSD.[119] It evaluated each of the guidelines using a methodology called the Appraisal of Guidelines for Research & Evaluation II (AGREE II) instrument. The following guidelines were reviewed:

> 1. Australian guidelines for the treatment of adults with Acute Stress Disorder and Post-traumatic Stress Disorder; Australian Centre for Post-traumatic Mental Health (ACPMH); 2013
>
> 2. Practice guideline for the treatment of patients with acute stress disorder and post-traumatic stress disorder; Agency for Healthcare Research Quality (US Department of Health and Human Services (AHRQ); 2008
>
> 3. 'The Last Frontier' Practice guidelines for treatment of complex trauma and trauma informed care and service delivery; Adults Surviving Child Abuse (ASCA); 2012
>
> 4. The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults; International Society for Traumatic Stress Studies (ISTSS); November 2012
>
> 5. Psychiatric Evaluation of Adults, Second Edition; American Psychiatric Association (APA) Practice Guidelines, November 2004 and a Guideline Watch; March 2009

6. VA/DoD clinical practice guideline for management of post-traumatic stress, Department of Veterans' Affairs and Department of Defense ; October 2010

7. Effective treatments for PTSD: Second Edition; Practice guidelines from International Society for Traumatic Stress Studies (ISTSS); 2010

8. The management of PTSD in adults and children in primary and secondary care; National Institute for Clinical Excellence (NICE); March 2005

9. Management of Anxiety Disorder; Clinical practice guidelines; Canadian Journal of Psychiatry; Vol 51, Supplement 2 Chapter 8; July 2006

The RANZCP working group concluded that all guidelines reviewed were of high quality and considered useful in the treatment of PTSD. It did however note that as the Australian Centre for Post-traumatic Mental Health (ACPMH) guidelines are Australian, they are likely to be more effective in a local context. It concluded that, as the evidence reviewed in all of the above nine guidelines was broadly similar, the adoption of any one of the guidelines by practitioners was appropriate.

Two of the above guidelines include the International Society for Traumatic Stress Studies (ISTSS) *Expert Consensus Treatment Guidelines for Complex PTSD in Adults*, and the *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Post-traumatic Stress Disorder* by the Australian Centre for Post-traumatic Mental Health (ACPMH) 2013. Reference information on both are included below:

An international approach

> The International Society for Traumatic Stress Studies is dedicated to sharing information about the effects of trauma and the discovery and dissemination of knowledge about policy, program and service initiatives that seek to reduce traumatic stressors and their immediate and long-term consequences.
>
> ISTSS provides a forum for the sharing of research, clinical strategies, public policy concerns and theoretical formulations on trauma around the world. We are the premier society for the exchange of professional knowledge and expertise in the field.
>
> Members of ISTSS include psychiatrists, psychologists, social workers, nurses, counselors, researchers, administrators, advocates, journalists, clergy, and others with an interest in the study and treatment of traumatic stress.

> ISTSS members come from a variety of clinical and non-clinical settings around the world, including public and private health facilities, private practice, universities, non-university research foundations and from many different cultural backgrounds.[120]

An Australian approach

> Five to 10 per cent of people will suffer from posttraumatic stress disorder (PTSD) at some point in their lives.
>
> The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder provide information about the most effective treatments for PTSD. They are the first national Guidelines that provide guidance on the treatment of children and teenagers who experience PTSD.
>
> The Guidelines aim to support high quality treatment of people with PTSD by providing a framework of best practice around which to structure treatment. While there has been growing consensus about the treatment of acute stress disorder and PTSD in recent years, approaches are varied and there is still a gap between evidence-based practice and routine clinical care.

Approved by the National Health and Medical Research Council (NHMRC), the Guidelines were developed by Phoenix Australia (formerly Australian Centre for Posttraumatic Mental Health) and a team of Australia's leading trauma experts, in collaboration with representatives of the professional associations for psychiatrists, psychologists, general practitioners, social workers, occupational therapists, mental health nurses, school counsellors, and service users. Recommendations were based on best practice evidence found through a systematic review of the Australian and international trauma literature.[121]

Conclusion—harnessing the chaos

A characteristic of debates around mental health and the ADF is the multitude of divergent groups with different and often contradictory views. This creates a set of political, social and administrative challenges for government. The task of integrating and co-ordinating the competing voices is significant. Leadership with authority and a capacity to bring together these disparate voices while forging a path forward that engages people, appears to be an essential element to optimising the potential of all those who seek to contribute. As noted, part of this puzzle is the relationship between the federal government's coordination and state-based service provision. Another feature of the debate is the range of vested interests that are at play, each of whom are keen to ensure markets for their own products and services. One suggestion that arose during the research for this paper was to establish a forum run by

professionals with subject matter expertise with a remit to address some of the identified issues around mental fitness. Currently, no forum exists through which the scope of the problem can be clearly defined and effective solutions planned. Such a forum would allow for the development of a new narrative focused on a professionally-set agenda.

The issue of the mental health of current serving ADF members and veterans is one that will always evoke a range of opinions and tensions between the organisations and individuals with a vested interest in this domain. One challenge arising for policymakers is how to encourage the development of high-quality research and audit arrangements to provide an objective analysis of emerging and current concerns. These findings would then require translation into legislation, policy and service implementation. This process depends on finding ways to facilitate collaborative dialogue between veterans, ESOs, federal government departments, state-based health departments, the medical profession and politicians. In part, this will require the development of a system of governance and independent oversight of the process. This role should also facilitate discourse between these parties. Another challenge is how to ensure that this kind of collaborative discourse and scrutiny feeds into a circle of continuous improvement of service delivery.

Further attention could usefully be paid to some systemic structural issues, such as the lack of clearly defined responsibility within the health system for addressing the divides and disjunctions between the responsible Commonwealth and state bodies that arise out of the structure of our Federation. This would ensure that an effective dialogue continues between the broader community health system and the veteran health system. The landscape of veterans' mental health is constantly changing in terms of demographics, the numbers and duration of deployments, the types of wars being fought and the evolution of the health system. As such, these issues require ongoing monitoring to achieve optimised outcomes for both veterans themselves and the public at large.

Opportunity

The current reduction in operational tempo, and the significant interest and momentum in the issue of mental health combine to make the present a key opportunity to progress mental health care for Defence personnel and veterans.[122] The challenge is for Defence to capitalise on these factors and become a leader in the field, promoting and ensuring the psychological wellbeing of its workforce.

From the First World War veterans who were neglected by a medical system which misunderstood the link between military service and psychological injuries, to the woefully inadequate treatment of Vietnam War veterans, by comparison, the status of mental health in

the Defence Force today is arguably in the best shape it has ever been. Encouragingly, there appears to exist from within its ranks, particularly in the senior leadership, a desire to continuously improve the way this issue is dealt with. While some activities around mental health and Defence appear chaotic, the challenge now is to harness the energy and direct the momentum in order to channel it into something of enduring benefit to serving members and veterans. With a small and captive audience as its workforce, the Australian Defence Force is well-placed to develop improved strategies for dealing with combat-related psychological trauma, reduced mental fitness and moral injury that other industries and nations will want to emulate. While we have come a long way from a very low starting point, the programs and services available are not yet effective and without significant investment in this issue now, there is the risk that the mistakes of the Vietnam War will be replicated, creating another long legacy of psychological injury from recent and current deployments.

Appendices

Appendix A—veteran testimonials

Each of the accounts below tells an intensely personal and harrowing story. Each is articulate and communicates something distinctive. Each account represents an Australian soldier. The stories relate to individual personal experiences in most cases, but in a small number, the experiences relate to a spouse or close personal friend. Unless otherwise stated, all these veterans had deployed to Iraq or Afghanistan, or both—some, multiple times each. I met these men and women on the Kokoda Track during a trek organised for recovering veterans. We spent eleven days together on the Track which overlapped with the 100 year Anzac anniversary of 2015. When we returned to Australia, I spoke to each of these veterans and recorded some of their experiences. I explicitly avoided asking them about their traumatic experiences on military deployments for several reasons. There are many such accounts in the public domain already and I wanted to avoid dredging up traumatic memories for these men and women, many of whom were struggling to cope with the pressures of life post-Army. I wanted to avoid the temptation of giving a sentimental and emotion-laden account that might detract from an objective evaluation of this complex issue and the presentation of some possible solutions. Instead, my focus in the questions I posed was to briefly catalogue the impact on their lives (to provide context) before turning to solutions and exploring what could be changed or done better. The following accounts are sometimes fragmented and confusing. I limited my editing of these stories in order to present the accounts as they were given. I have likewise avoided the temptation to categorise these comments into like groups as I felt it would break the flow of each story. The comments are often revealing and set the tone for a discussion on what are complex but urgent issues. Identifying information has been changed to protect the identities of these men and women.

Samuel did 20 years in the Infantry, working his way through the Other Ranks to become a Warrant Officer. He was a man of few words. He was not particularly comfortable talking about the subject himself and also remarked that he felt it was difficult to get even his close mates to talk about PTSD.

> I haven't suffered from PTSD myself but mates and family have. As an observer, my father-in-law is a Vietnam vet and suffers from PTSD, dementia and a host of physical ailments; mates suffer from PTSD and depression.
>
> …
>
> [Relationship with Defence] Generally it seems to be one of mistrust, especially the hierarchy and decision makers if in their mind it contributed to their injuries or the situation that resulted in the condition.
>
> …
>
> [Department of Veterans' Affairs] Always busy and stretched. You are a number, as more defence personnel are diagnosed.
>
> …
>
> [Community organisations] Usually find out about these organisations through mates, but they are set up by people looking after their own and by charity from others because government and defence had nothing in place. There are issues that are not treated fairly, not enough.
>
> They do not trust and don't feel great having to talk to psychologists and counsellors. There is stigma involved with sharing with strangers. They say there is no stigma, but there is still. It is still a mindset amongst soldiers and officers generally of a person who can't sort out his own stuff. I have witnessed negative stigma from PTSD. People still whisper and spread stories. There is still not enough education in the public and so not as much empathy for people's situations. There are not enough services and support available for sufferers of PTSD.
>
> A lot of it is about mindset. Think of the soldier's welfare and what is best for them and their loved ones. You sent them there and when they return their lives are never the same. As a soldier, you are trained from recruit training to kill or subdue your enemy. To be the best and uphold the traditions of the Anzacs. As men, we are too scared to say we are not good enough or that we need help at times. We would die for each other but we will not talk about our fears to each other because the vulnerability and embarrassment is too much at times. This leads to disempowerment, isolation, confusion and despair, where we are helpless. Many choose suicide to end it or live lives of quiet desperation. It affects

the community at large. It needs community help. It needs mates helping each other and looking out for each other. It needs education and listening to the veterans. It needs funds for rehabilitation.

John is a Senior Non-Commissioned Officer who served in the Infantry for more than 20 years. He was diagnosed with anxiety and depression in 2014.

> Personally it was a difficult time as I didn't really have any answers why I was depressed and I couldn't attribute it to any one incident. It was confusing and embarrassing as I had no control of my emotions and could not trust myself to keep it all in check. Initially it was something I tried to hide, but it got to a stage where I was totally useless and couldn't concentrate on anything except trying to hide my condition.
>
> I have an ongoing relationship with Defence and am back on full time duties; however, I feel a disconnect with Army and no longer believe they have my best interests in mind. My issues with depression are not something that are gone altogether but more a case of something I manage on a day-to-day basis. There are times where I feel very down or agitated but I now have tools for keeping on top of these feelings and I know that I have the ability to get counselling if it gets to be something more than I can handle. My concern is now that although I have only been fully upgraded in the last month or so, I will potentially be posted out of my current location at the end of 2015 despite the fact that it means I will be posted married-separated (my partner is unable to break her current work contract until 2018). I just purchased my house in Sydney in August 2014 and my daughters live with their Mum in Wollongong which is only a two hour drive from my current posted locality. A posting to somewhere interstate is highly likely and the Army has not given any thought to the pressures that a posting away will present, or how it may affect my health and wellbeing. This is why I say that I don't believe the Army has my best interests in mind.
>
> When I was diagnosed as having depression and anxiety issues, I was effectively downgraded medically. The period of MEC [Medical Employment Classification] downgrade was approximately 12 months, during which time I was not eligible to participate in any courses, exercises, training, weapon handling, driving of a military vehicle, etc. At certain ranks and windows in a soldier's career you only have limited opportunity to be considered for promotion or attendance on promotion and career advancement courses. If you are ineligible for these activities due to being MEC downgraded, you essentially miss the window and that opportunity has flow-on effects for the remainder of your career. For example, DSCMA [Directorate Soldier Career Management Agency] will compare you against your peers for such things as promotion by looking at everyone's annual PARs [Performance Appraisal Reports] over a period of 3–5 yrs. If you have been unable to participate in all activities and exercises, then your annual PAR will reflect this and you are no longer going to be competitive with your peers for promotion, courses or certain jobs.

I believe [there are enough services and support for sufferers of mental illness], yes. In my opinion, Defence have worked hard to implement and provide support services to address issues and provide more opportunities than most civilian workplaces.

I think most people's perception of mental health is that they have no real understanding of the issues until they, or someone close to them, is affected. This was most certainly the case for me. I guess what I am trying to say is that previously I was very sceptical of anyone who claimed to have PTSD, because I thought it only happened to people who were weak to begin with.

Sara is the wife of a veteran of Iraq:

> I have several friends who have PTSD—most aren't very open about it—and it manifests differently in each. To me they all seem lost, they need someone (either an actual person or an organisation) who will actually listen and guide them. Most turn to their mates from the army, those that fall through the cracks seem to be those who have moved back home, and subsequently have lost contact with army friends, or who don't want to ask for help. Some don't know what services are on offer, or where to find them, or think it will cost money that they don't have. My personal experience with diggers I know with PTSD has been quiet conversations about the experiences they've had overseas, what they've done, what they've seen and it mostly ends with 'that's just how it is I guess'. There are a number of diggers I know with quite serious physical injuries, but they hide them from the army as they won't be able to continue in their role if the army knew.
>
> [Are there enough services/support available for sufferers of PTSD/mental health issues, in your experience?] No, particularly in regards to homelessness. I think there also needs to be greater support for those who are transitioning from ADF life to the civilian world. Greater support in getting ADF qualifications recognised (or ADF being recognised as a training provider would be even better so that qualifications don't need to be transferred), helping ex-ADF members find work (particularly work that makes them feel valued). I have a friend who is a highly-qualified Combat Engineer, who did three trips to Afghanistan, left the army and went back to working at the freezer in Coles where he was before he joined—hardly a recognition of his skills and it hugely devalued him.
>
> I think there needs to be greater provision of services for those currently serving and a cultural change is required from senior members of the ADF (not so much officer level, more Sergeant, WO2 and WO1 level where the culture really hasn't changed much in 20 years). I've heard WO1s call blokes who are genuinely injured 'lingers' [malingerers] on more than one occasion—disparaging at best and downright contemptible in light of genuine illness and injury.
>
> Currently it seems that the system is geared in such a way as to place an onus of proof on the veteran, so rather than 'how can we help you?', the system is 'what do you want? Prove that you deserve it'. Clearly this would add stress to an already stressful situation. I know that my husband has three outstanding claims that he's yet to make because there's too much administration involved and he thinks it's not worth it to make a claim—too much stress involved for little result. I think the system is overly complex, especially in light of several factors (which I think are currently over-looked). They are as follows:
>
> - The education standard of a large percentage of people from the armed forces is actually relatively low, especially diggers. Many haven't finished school, and those that have tend

towards the practical side of the equation, rather than scholarship. As such, multiple forms and reporting requirements are not only daunting, but unachievable for some.

- People with a service-related injury are already stressed—tackling a system like DVA, especially with the waiting times involved, is only going to add to this stress. Waiting times must be reduced, particularly involving those with mental illness. I would suggest a triage system whereby an immediate assessment is made of the duress that a person who presents is under, and emergency services offered accordingly. If it saves one life, a system like this has paid for itself.

- I think the system needs to be more accommodating and better at communicating what service members need to provide. It needs to be made clear what a claimant needs to provide and the rationale behind why they need to provide the information.

- I think that DVA needs to be clear in the turnaround time on claims. Clear and direct communication is what service members are used to, and if you provide a clear time frame for someone, they can see an end point, which will hugely reduce stress.

- I think the general attitude of DVA should be 'what can we do for you/how can we help you?'. Careful consideration needs to be given to staffing and the manner in which staff deal with service members who are making claims.

I think the ADF medical system needs considerable change overall. It's backward at best and risk-averse in the extreme. Some of the PTSD issues stem from service personnel being medically downgraded and considered unfit for their role, when the reality is with correct physio and support services there is no reason they can't continue in their role. I know a considerable number of ADF members who use outside services, and pay for them out of their own pocket, because the services provided by the army medically are inadequate and antiquated. Further overhaul of PT practices within the army, and rehabilitation programs need genuine improvement. Having worked on an army base and seen the rehab for physical injuries it is hopelessly inadequate; with people not getting better physically, this is only going to add to mental health issues.

The following are the words of Charlie who served in the Army for eight years.

> Yes, I have a lot of mates who suffered from PTSD. Some committed suicide but I'm unsure whether it was totally PTSD, or that started the downwards spiral and drugs/alcohol, or something else, contributed to, or sped up, the process. I have mates at the moment who are suffering in some form or another and others I suspect, but haven't spoken to about it.
>
> Myself personally, I don't believe I suffer from PTSD. I have gone through many of the same experiences as some mates above, minus the full-on combat, poverty, death, riots, locals killing each other. The way I look at it is that everyone changes from life experiences whether it be a football grand final that you won that will always be remembered, or a deployment as such. If anything, I get agitated easily and have no patience for laziness and not doing the right thing by others; however, this is most likely a family trait shown in others who have not served. I do have streaks of—let's call them 'outbreaks'—where I tend to lose my shit for a few seconds where I can do silly things like road rage or abuse, but again that can't be fully attributed to deployments. They are also very rare. I believe it's an integration back into society thing, and is often just called PTSD because it's easier to put something into a category rather than understand the deeper issue—that being that defence is a lifestyle more than a job and once leaving that lifestyle, things change. You see it in football players a lot where they are placed on pedestals and are given everything, and upon leaving, they struggle because of that lifestyle change and adapting to the real world.
>
> I have hurt myself a number of times and that was one of the leading reasons for my discharge, but it was at my own will. I did however have DVA pay for a full ankle surgery in 200X. I still miss it and am thinking about joining as a medic, my current civilian trade. Plus my wife still serves, so I usually go with her to happy hour every fortnight/month and mix with defence.
>
> …
>
> [Contact with DVA] I receive newsletters off them quarterly due to my ankle surgery and white card I have for that.
>
> …
>
> [Contact with community organisations] Apart from being part of the Admin team for the Kokoda event, nothing.
>
> [Career effects of a PTSD diagnosis] From a recent experience of seeing a family friend suffer from this, from what I have seen, when it came out he was already in a lot of trouble so it didn't help the situation. His career was put on hold; however, I think this

progression probably would have happened anyway. He was medically discharged and from what I've seen as an outsider not knowing the thought process behind both parties, is that they are funnelled into it. To a degree I think it's fair as you don't want these people bringing down the team due to the negativity and such. To the actual PTSD sufferer it's probably not fair, but I think more attention needs to be paid to it as a medical condition maybe, and coaching to get back on track and re-enter the workforce. Many times I've seen PTSD suffers do silly or stupid things which gets them in trouble and moved on before coming to the realisation of the motivation behind these actions. By this stage it's usually been too late.

[Stigma] Yes, and I was one of these people who looked upon it negatively as a younger soldier. Having gone through some of the experiences myself I could not see why people who signed up to do just that, could break easily. I never said anything and tended to move away from people who were suffering. These days I don't believe that, possibly because of some of the guys I used to look up to as a younger soldier who now suffer or/and because of the scale of it within Defence/ex-Defence.

Reasons that I believe I didn't suffer like or as bad as others: I felt supported during operations, such as mail continuity. I had a chance to get away everyday. My own diary that I wrote everyday where I could, or at least caught up when I could. There was relaxed leadership, always away from command and able to concentrate on the job. I grew up sheltered from the world, but rough and tough. Grew up competitive as in not giving up. I keep forgetting not only events, but unimportant things (can recall clearly and with more detail when prompted or I read my diary). I get distracted easy.

I abused alcohol on return. Being sick every morning and not realising till I put my hand or foot into it on return from my first deployment. I felt a lack of sympathy. Being able to switch emotion off when needed and being able to concentrate on the job, whatever that is, home or abroad. I have done some road rage, dangerous acts on the road. High expectations in my relationship has been stressful.

Possible reasons that might contribute to PTSD:

- Lack of support during and after [deployments]
- No timeout, always on the job
- High threat level
- Stressful situations
- Pessimist

- Coming to terms with struggling
- Long-term health effects
- Lack of recognition, or wrong recognition
- Band-aid solutions

For DVA to improve they need to:

- Not group or pool people into groups
- Tailor packages to individuals
- Psych or councillor assigned to member should have power to make decisions
- Bureaucracy and red tape don't work so well when dealing with human suffering as every need is different, and because of the complexity of PTSD, most coming forward need help immediately, without having to go through some red tape that stipulates hoops they need to jump through to get there.
- Swift and immediate help and support in whatever capability is needed. For example, gym, martial arts, medication—I believe sport and PT are excellent for the mind.
- Encouraging lifestyle habits and change, being healthy and active
- Having an end state in mind, for example, being on your own two feet with job
- Remembering outside influences contribute to stress
- Having timeout to wind down
- Feeling worthwhile
- Veteran cards and discounts
- More recognition of veterans on Anzac Day
- The opportunity to talk about experiences in a safe and comfortable setting
- Possible short courses to carers, parents, partners and even children
- Knowing, regardless of job role, where you fit in the scheme of things, that it is a worthy and much needed asset for the greater overall picture—completion of the mission. That goes

to combat roles also, as it's easy to see where they fit in, but not always evident where their support does.

- List of benefits to veterans—on a website that's easy to use. State to state, town to town, as many business and organisations do offer stuff to veterans, it's just not known about
- DVA fixing their name
- Poor quality
- You have to bung it on to get anything
- Possibly too much money spent on contracts that can be done in-house. For example, health and gym memberships
- Using organisations effectively, like the RSL
- Society is changing. No longer sit over beers and talk. They prefer adventure, gym, lifestyle
- Library support
- Education support with end state
- Online courses
- Having the veteran in mind and a clear end state decided by both parties, not funnelled into one.
- Possible ongoing communication. If not, set time periods via phone and email, not SMS.

I tried to use my own experiences as I believe I cope very well when a lot of mates have fallen to the wayside. I also tried to think of reasons that contribute to it. One thing I thought of a long time ago is that on enlistment with all the testing done, a personality test should also be done and used down the track to see if a certain type of personality does tend to suffer more then another type. I know they do a similar test on the SF testing, but that is more to see if you would, or could, be suited to that role. That way, once studies have been done, more can be done to monitor those that are more prone.

In my experience, in an infantry company the OC is the one that dictates the outcome, readiness, fitness and strength of it. You can have average CSMs [Company Sergeant Majors] and SGTs, however if you have great OCs [Officer Commanding] and good Corporals, the diggers can be manipulated easily enough. I've been lucky and had pretty good SGTs, CPLs and OCs, however if a poor OC is in charge that's when trouble can set in, including depression. Two great OCs that come to mind are X, whom I believe is

now the 1RAR CO [Commanding Officer] or has just left, and X, who, if still in, would be close to a Brigadier or General, possibly in Canberra. Strong leadership is definitely a key in encouraging, maintaining and developing a soldier mentally, as well as physically. I think a lot more effort needs to be placed upon OCs and CPLs to maintain a soldier's mental capability.

Harry spent 17 years in the Australian Regular Army. He is a veteran of East Timor and Afghanistan, where he was seriously wounded.

> My father and his friends [suffered from PTSD]. I was told stories of military service and I was raised under very strict rules. I told my father and promised myself, I would not be like him because of the anxiety and stress he put onto my brother and I. Military friends, former and still serving—I have numerous friends that show signs of PTSD I believe, and they have been diagnosed because of their comments and actions. At times I can feel anxious and stressed when being around them. I have witnessed a lot of them always living in the moment, what happened in Timor, Iraq, Afghanistan, which I try to limit myself from.
>
> I have been diagnosed with PTSD and I know I had it from East Timor (1999) when a few incidents occurred in Australia with my wife at the time. I have been a strong believer that PTSD makes you stronger, I felt you are looked at differently in the Army if you spoke out, and possibly lose command and rank. I believe in self-medication and I have only been medicated when I have been admitted to hospitals for PTSD breakdowns. I have had numerous breakdowns, with only a few reported. When reported and admitted to hospital I have always been medicated, which I would take myself off when discharged because I didn't like the feeling.
>
> I completed a PTSD course in 2010, which made me question my mindset. The course raised a number of issues and I didn't like the way people who didn't know me, perceived me. Part of my self-medication is routine and exercise. I find routine and exercise helps with slowing down my thinking and helps me to change my mindset from being passive-aggressive to passive, I feel.
>
> As a single father (divorced) and a competitor in a few sports, I am forced to interact with society. This is difficult because of my thoughts and feelings, but also because of the way I perceive society viewing my losses: sometimes I think people are looking at me when they are not, or people are staring. Interacting with society is cognitively tiring, which then physically tires me. I know most of my PTSD triggers, although some just pop up, and I try to implement strategies to reduce my anxiety and stress, which works sometimes. If my anxiety and stress takes hold, I become quickly depressed and it takes a lot of effort to get out of my depressive state, up to two months. There are tell-tale signs that I know let me know I'm depressed because I'm not myself; I find it hard to see that I'm in a depressive state, it is difficult when you want to be better.
>
> On top of being forced to interact with society as a competitor and a single father, attending uni has been my grounding. It was very difficult to attend uni for two years because of my thoughts, feelings, and how people perceived my actions, passive-aggressive. Uni was pass or fail to me; I don't like to fail and I needed to find my identity

again, so I was forced to interact with young students, middle-age students, and lectures. Apart from the routine of attending lectures, I found the lectures empowering and educational. They helped me to view things differently, but more importantly the lectures slow down my thinking process, I feel. To focus, I had to listen and to be present mentally and physically. I try to reduce my contact with former and current soldiers that live in the past; it doesn't help me where my anxiety is increased.

…

[Ongoing relationship with Defence] I have a number of friends in defence, but I have found that I am no longer a part of their circle and culture. They go field, play sport with units; I can't get access onto the base, therefore I don't fit. I do speak to some of them out of Defence, but I have to make the effort as they are field or tired from working. Military friends that have similar sports interests are in more regular contact because they wish to train, or wish to know what is the next competition. I have only two friends in this group. I keep in contact with about eight Defence personnel all over Australia and numerous former soldiers via email, social media, or social meet-ups.

…

[Contact with the Department of Veterans' Affairs] I usually go through my appointed occupational therapist to advocate on my behalf because we need to justify for my needs. I have a DVA case manager that I did speak to from time-to-time when I make contact...

Since my discharge from Defence I have had a lot of frustration with my transition to DVA. What was allowed and proved to be a need in Defence, needed to be proven again and reasons for it [provided] to DVA. There is no link between the two, creating stress to families and individuals.

A lot of the families and individual's stress and frustration also comes from Comsuper; incorrect allowance and very long time frames for replies... Families are waiting up to 12 months for determinations to be reconsidered.

…

[Contact with community organisations] I try to socialise through competitions that are organised [by] community organisation groups. I am also involved with Soldier On. Any money given to me for motivational presentations is asked to be given to Soldier On. Soldier On has assisted me to compete in the Mark Webber Challenge and to hike the Kokoda Trail. I believe all policies need to be reviewed within DVA and Comsuper. DVA policies need to reflect on today's technology, devices, and evidence-based research to help clients in a 'quick and swift' time frame. Comsuper needs to award people their correct classification and if a review is needed, it is reviewed in two–three

months, compress reply and subject views [sic] create financial hardship and stress on families and individuals. It would also be beneficial if DVA has access to Defence records or items approved, to assist an individual and family's needs is flagged and passed on—this may mean all three groups (DVA, Comsuper and [Defence]) employ a computer system for former soldiers and their families quickly, not prolong results.

…

[Stigma] Yes! I have seen an officer withdrawn from a promotional course; I have seen people alienating soldiers in Defence because they have PTSD; they walk around on eggshells and talk behind their back, isolate soldiers from exercises and functions...

…

[Services and support] Yes! There are a lot of services available, people just need to be educated about the services they provide and how families and individuals can get in contact with them. It can get overwhelming as well because there are so many services.

…

[Policy suggestions] As stated above, I have found routine, competing, and going to uni the best for me. I strongly believe it is about changing an individual's mindset and giving them the tools. At the same time, I do not think PTSD is something that people should 'walk on eggshells' about. Soldiers need to take responsibility as much as those that provide the tools to assist.

Everyone is different, but ownership in one's actions is a must too, from what I have learnt. I have seen too many people blame their PTSD and medication for their actions. I have seen Defence try to deal with this; they are trying to move forward, positively, but people need to take responsibility too, it is easy to blame others and to take the easy road. Sorry, but this is draining…

David was an infantry soldier and was wounded during his tour of Afghanistan.

> Many men I served with suffered PTSD. Sadly, I could not realise [sic] the symptoms until I discharged and enrolled in youth work, learning about mental illnesses and disorders. My Sergeant overseas wanted nothing more than to capture and kill the Taliban. In some circumstances, almost putting soldiers in jeopardy to push further and fight harder. His psych screening when he returned was also concerning. Question: What was the best thing about Afghanistan? Answer: Killing Taliban. Q. What was the worst thing about Afghan? A. Not killing enough.
>
> My boss (Lieutenant) shot and killed a Taliban suicide bomber.[He] now suffers severe PTSD and struggles to live days without seeing him in his life. My Corporal was bipolar. Happy one minute, then throwing helmets, magazines and whatever he could put his hands on to enforce his authority. Friends of mine have confided in me about their suicidal thoughts and attempts; struggling to make ends meet in and out of the Defence Force. My Sergeant was psychologically discharged from the army due to an unstable mind.
>
> I have had a good stable relationship with DVA but I was also very fortunate having a grade A+ case manager when I was first injured. She fought and took on everything that aided my initial recovery. When I discharged from the army I went straight to my local RSL and sought out a dedicated advocate. For me, he was a great help and managed compensation matters, mental health professionals and educational benefits.
>
> A Sergeant from my sister platoon was blown up from an IED [Improvised Explosive Device] attack on my tour in 200X. Both of his ankles were shattered, tibia and fibula with fractures all up them and he broke his arm also. He is concurrently undergoing surgeries to this date. He has had major involvement with 'Soldier On' whom I believe has helped him financially and with aiding equipment such as chairs, a T.V. and a laptop. He has also had involvement with the 'Mates for Mates' sailing team. He was always proactive, which aided his mental health.
>
> I do not believe they [issues described] were [addressed fairly]. All members, including myself, were given the green light upon returning to Australia after our tour to Afghanistan. I clearly remember all three of my screenings, two of which were with young females under the age of 25 with no history of deployment, and after a few quick general questions I walked out the door after 10 minutes. I do not understand how I was so easily assessed and given back to the battalion. I had only just turned 19, shot through both thighs, nightmares each evening and total confusion from chronic nerve damage. I do not understand why critical questions aiming to discover depth within my mind were not drawn to the surface and assessed professionally. Also, if a Sergeant suggested that 'not killing enough Taliban' was a bad thing, how is someone allowed to continue in that

role for a further four years? I respected and admired him but someone of this stability could severely affect upcoming soldiers who look to Sergeants for support and knowledge.

If you went to the padre or psych, [you were seen as], for lack of a better word, [a] 'poofter, faggot or weak cu*t'; sorry for the use of this language but to understand how demoralising it was for some soldiers, these words must be used. It started from higher ranks such as a Sergeant or Corporal and as you could imagine, it only manifested tenfold amongst the diggers. I clearly remember one soldier who was thrown into a cage, locked in there like an animal, a cold bucket of water tossed in and a broomstick poked through the gaps. This is a severe case but stands true. He was later psychologically discharged from the Army. Of course that's not fair. This was not uncommon and rank just turned a blind eye or walked out of the room when this behaviour was developing. A friend recently told me that he believes some of the courageous men he served with, were the diggers that copped sh*t every single day of their service. They were belittled, demoralised, but yet they continued to stand by their mates and serve their duty. There are enough services, though once in the civilian society your options are limited, especially if you are not around Defence establishments. Mental health is thankfully evolving and becoming more recognised, but my view is one of a civilian now. I am unsure what the stigma is like within the pearly gates.

I believe to reach out to the younger veterans, there needs to be more involvement recreationally. Four-wheel drive trips, hiking, kayaking, mountain biking, gardening, or surfing. I personally have benefitted greatly through the outdoor environment. I believe the R.S.Ls are doing a fantastic job but young diggers don't want to hang out and drink in a pub. Outdoor trips could be run and sponsored by the R.S.L, using the outdoors as the natural therapeutic healing option alongside medical professionals.

The environment helps people know they're real again. An example is an ex-veteran friend of mine who suffers depression and severe anxiety. He surfs and bases his life around it. Why? Because when he is out behind the surf break, he feels completely safe, away from humans and life's little dramas. When he surfs large waves the adrenaline is the closest feeling he can relate with, when we fought together in Afghanistan.

We need to look outside the box, literally; I see a psychologist and I can feel the benefits of us working together in the medical room. Many veterans are intimidated and threatened by this little white box we see health professionals in. [We] need to use different environments with health professions together. The R.S.L of Melbourne, the duckboard is starting a programme called 'dogs for diggers'; this is a fantastic idea. Brilliant in fact, I hope it succeeds.

Bill served in Special Forces in the 1960s and 1970s and is a veteran of Vietnam.

> I suffer from PTSD myself; however, I can manage symptoms and the occasional meltdown with strategies including knowing and avoiding triggers. [I was] discharged in '73 after a twelve year career as an Officer with SASR [Special Air Services Regiment] Commandos and the RAR [Royal Australian Regiment]. I was awarded the Military Cross, Vietnam 1966–67. I wrote a book about my platoon in Vietnam. Stigma still is a key issue. In the past, I didn't want people to know I had a mental illness. I was too embarrassed and too frightened to admit fear of ridicule in a macho environment; fear of not being redeployed, promoted, or being overlooked for key sensitive postings.
>
> CDF [Chief of the Defence Force] and CA [Chief of Army] understand the issue—they have genuine empathy; however, stigma persists at JNCO [Junior Non-Commissioned Officer] and soldier level. A key failure in centralised health changes is the loss of RMOs (Regimental Medical Officer) in the Royal Australian Regiment (RAR) Infantry Battalions. Part of the problem as I see it, is that soldiers get on an adrenaline high that you never come down from, leading to self-medication through alcohol.
>
> I've made a life for myself in spite of my condition, but there are still issues I need to control. I didn't know I had PTSD, didn't know what it was until 1988, during a social gathering with old Army colleagues, and while drinking, many of my Vietnam experiences came to the surface. I got home and my family had never heard me swear nor seen me cry. I just kept repeating 'nobody fu*king understands'. In the morning I apologised profusely and my wife told me 'you've got a problem and you have to do something about it'.
>
> I got a lot of help from a psych with army knowledge. Before I wouldn't discuss my PTSD with anyone, including my own family. Now I believe I can help others by talking about it. I couldn't relate to a pretty 23 year old psych but would debrief with a mate who has been through similar. I don't think there is a solution to the whole problem. It doesn't exist. We need to thank all service people and then encourage them to seek help if they need it. Families should also be able to get this help because they often suffer the most.
>
> The Australian Defence Force and Department of Veterans' Affairs has a duty of care for the whole of life for all vets. [There is a] need to address the gap between discharge and DVA registration. I'd like to see a national ID card to identify veterans as such. The key issues to my mind are soldiers and suicide and self-harm, homelessness, crime and being put in gaol, and domestic violence. There are no stats available on these things. This will have a financial saving as once [you are]TPI [Totally and Permanently Incapacitated] you are paying for a person's lifetime. There should be more pre-deployment training, to harden soldiers up mentally, know what to expect. Politicians must know it is an

accepted condition that will not go away and requires early intervention, and it shouldn't preclude someone from employment.

Marcus joined in the 1990s as an Army Sergeant. He is now awaiting discharge on medical grounds that are mental health-related.

> They gave me as many drugs as they could, that was the treatment. I got PTSD from my first trip in 200X—I was lucky, I got in under the old scheme; my mate told me to get in before the system changes and it becomes harder; I got a good advocate, a psych, I was 26 years old. He asked me if I wanted to retire now? I said 'no' so he made me 75%.
>
> Back then I kept it to myself, there was a lot of stigma in that era, it wasn't discussed in the early 2000s; 'you're a weak cu*t'; kept it to myself and did not receive any treatment for ten years; it can build up with all the moving around they make you do, it puts strain on your relationship and you can't make any friends. I still get depression and anxiety and flashbacks.
>
> Didn't go through Defence; I did give them snippets of what was wrong but they didn't do anything with that. You do your POPS [Post Operational Psychological Screen] after three months and that was it. And, if it brought up something, there's no follow up, no one asked 'are you alright mate?'
>
> Defence will get caught short in the future with veterans coming home from Iraq and Afghanistan. Army are not expecting it will happen. Others will say: 'You're treating me like sh*t, I'm out'. It leads to problems with alcohol and they are not followed up. I have been drinking a slab a day for 14 years. I didn't have the confidence to go the psych within army, they didn't understand. Civ [civilian] psychologist was good, now I'm making progress. I went to Ward 17, I had a total breakdown, they discharged me and I was re-admitted. Alcohol with meds circle goes around, long process—I'm quoting psychs.
>
> Will never get over it, you've seen what you've seen, some struggle to deal with it. If surprised by fireworks I jump, I look at every person in a shopping centre so I know they are doing what they are supposed to be doing and are not a threat to me or my family. It means I stay at home a lot which leads to depression and drinking and medication.
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> …
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> [DVA] No dramas, they were excellent; I had a great advocate, it didn't cost me nothing [sic]; I got a white card in three months and I got a gold card now. Some have struggled with DVA, now they've got to get different proof and different opinions.
>
> …
>
> [Fair treatment] Long process, it's taken them one year and I'm still waiting for discharge; I don't know, Canberra to sign off. Defence is losing a hell of a lot of money.

They know that, they know the system is sh*t. The psych told me it's a sh*t system; you just have to turn up and show your face, they don't treat you or nothing.

Ward 17 at the Austin civilian psych, I now have the opportunity to go back to Ward 17; one psych took an interest in my case, he set it all up for me, I've had a gravy train ride … lucky.

PTSD main thing (in my career), it's hard to say. Would get to a year and my arse would drop out. I was outspoken and critical of the moochers so they moved me around a lot. Family wife serving member, she's been diagnosed with PTSD from a civilian psych but hasn't claimed DVA; she's biding her time, enjoying her career for now.

Stigma [in the] 1990s, RAP [Regimental Aide Post] your section commander: 'you're weak'. If you weren't participating then you were ostracised; less now, DVDs recognising our soldiers have PTSD but too late.

They weren't ready for East Timor. They got to fix the medical side; Defence, if you bring up stuff, needs to follow up [on an] ongoing [basis]. PTSD may linger in the back of ya [sic] and comes back out. Reliving all your other sh*t. Once diagnosed, a slick transition from military to civilian is needed. Still waiting [puts] 'I'm in or out' pressure on your family. Nah not really, I've been lucky, the system has failed others recently. If you don't pass that, you've going to get the arse, what defence wants. Army will cop landslide of cases, they're not prepared, everyone's experienced something that could trigger PTSD.

Denise served for nine years and was medically discharged on mental health grounds.

> During my service I did not, that I recall, encounter anyone suffering from mental illness; I did come across many during my service who, like me, were recipients of abuse both administrative and sexual in nature that caused our behaviours to change. Since leaving the service I have come into contact with people, but feel as though more military people would be better suited. PTSD from Defence seems foreign to those outside of it.
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> …
>
> [Medically/personally] I become anti-social, often bed-ridden, due to high anxiety and inability to cope; I am on anti-depressants and see my psychiatrist weekly; during tougher times, up to three times a week.
>
> …
>
> [Ongoing relationship with Defence] Not much, if any, except to get service files.
>
> …
>
> [Contact with the Department of Veterans' Affairs] Has been horrible. Several times I have been given misinformation, delayed and also mistreated. Recently, their social worker located in the Sydney office that deals primarily with sexual abuse found it amazing that I would appeal the recent DVA decision around the rape and gang rape.
>
> …
>
> [Fair treatment] No PTSD can appear to DVA like a blanket medical term. Everyone has it, so it is not taken seriously. They fail to see that in a majority of cases, it is real. That just because at times we put on this façade that everything is wonderful, [doesn't mean] we are [not] actually thinking how can I end this pain. I have not been able to hold down employment without breaking down, or extended medical leave. Since 200X, I have not worked in a normal position and find that one hour of teaching meditation a week can be stressful.
>
> …
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> [Have you witnessed the effects of mental health related stigma?] All the time with DVA; outside yes, but mainly because people do not understand. Once they get to know this is real, then they are compassionate. I can understand from the government's point of view that there needs to be some boundaries set so it does not become a free ride for those who are not affected. However, PTSD is not fun and goes on for years. Maybe put some of these workers in the field for a day or even really listen to us, live our lives for a

week. Wearing nappies because you are too disturbed to leave your bed to go to the toilet three metres away in your own home is not fun.

Sometimes it is hard for me to even fathom that I have PTSD and that what I go through is what others go through daily. My girlfriend in Sydney has spent time at the DVA hospital in the psych ward and says that has been helpful. Hospitals for me do the opposite, although I admit I have never tried the DVA hospital, (I would not even know if Perth has one). It is hard to comprehend how I have it, unlike many others who have served and had to shoot people, all I had was a rape, sexual assault and a gang rape, as well as various administrative screw-ups and medical mistreatment after a major car accident causing brain damage—all documented on medical and personnel files. However, I do have it and if I have a hard time understanding it, I can see how others do. There is no 'my story is worse than yours', or one event being seen as less stressful. I am very fortunate that the psychiatrist I see in Perth is a leader in his field and therefore very knowledgeable and supportive. I also understand there are variances in PTSD and that mine is a multiple or complex case as the abuse spanned over seven years, as well as the last 16 years from leaving the Defence Force. It has taken me this long to find the right doctors and support to even re-start many of the appeal processes. I have no set trigger that stimulates an onset of behaviour; mine varies from a bowl of porridge one day, which I eat most mornings, to a loud noise another day, to someone not sitting right. We are sending our Defence to wars so we need to also ensure that we have the medical support for them when they get back.

The following are Gary's words:

> I served with 1RAR from 200X until 200X in the Army Royal Australian Regiment Infantry. Private proficient. I would like to elaborate; my promotion was held back due to a platoon commander who had no idea who I was or what I had done, after I informed him that I had a back injury and leg injury that I had sustained whilst on SAS selection in Perth. He then commented by saying 'weak back, weak heart; I don't feel that you will need your promotion'.
>
> I have been diagnosed with PTSD and Chronic Depressive Disorder. I'm not sure how it has affected me on a medical level, however, on a personal level, I don't sleep very well, I have a tendency to wander in my sleep; some of these wanders have me stripping bedding off the bed, turning all the lights in the house on, opening cupboard doors. I think I have snakes in my bed; I have had my partner terrified because I have been so sure that there are snakes in the bed or in the room. My partner wakes up with me sitting on the end of the bed. I have night terrors that are wide and varied. The list goes on with my sleep issues. I have a problem with my mental focus sometimes; the doctor told me I hyper focus, which means that when I'm in one of my moods I will concentrate and focus on the task at hand so intently that I don't have any idea of the consequences as to what is happening around me. The best way to describe it is that I will pull a whole car apart and destroy it just to get the CD out of the stereo; [it's] all about achieving my goal. I have extreme anger outbursts for minor reasons.
>
> I have no ongoing relationship with Defence. The only contact that I have had with DVA is to have my physio and my counselling paid for. Soldier On Kokoda was the first community organisation that I had contact with. My contact with the whole venture was more of a support role; I was not one of the sponsored wounded on the trip. I chose to keep relatively quiet about my physical injuries and I don't generally discuss my mental issues. I chose to help with the Kokoda trip as a bit of therapy for myself, I suppose to gain a little perspective on how other servicemen are dealing with things.
>
> My discharge and my compensation claim was extremely unfair. I was discharged before my medical treatment was done; mere weeks before my discharge paperwork was sent to me I had been escorted to the base counsellor after an extreme episode. Therefore, in hindsight I was not fit to be released into the world. As for my compensation claim, I was medical 401 discharged due to an injury I sustained while on SAS selection in Perth; the compensation board denied liability for five long years. How can you deny liability for an injury that was sustained on a course for work which the Army then sacked me for? I have kept my PTSD and Chronic Depressive Disorder very quiet, so at this stage it has had minimal effect on my work life; I do find that I have time off on occasion due to 'not feeling quite right', but at this stage my employer is kept very much in the dark and I

deal with my issues at home. Well it's not really fair, but I also don't want my employer and my work mates thinking that I'm nuts.

I remember a guy that I was serving with at the school of infantry finally lost it; he was taken to hospital and then transferred to the vet hospital at X. I remember when the platoon commander informed me of what had happened, he laughed and proceeded to say 'for fu*k's sake, he only served in East Timor; what the fu*k did he see, he's full of sh*t'. Bearing in mind that this particular platoon commander had never been on operations.

…

I just went to a counsellor in X because I had had a catastrophic breakdown; I had no idea why, or what was going on. I never thought that it was PTSD so I never really looked for another counsellor. The guy that I talk to is not military but has a lot to do with military patients… I suppose for me what would have helped is some support on discharge; they say there is support, but there isn't. As soon as you have your discharge papers you are treated like a leper. I had the door slap my butt on the way out. That's a whole other story...

Susan

By way of introduction I was medically discharged from the Army, Military Police with PTSD, depression and eating disorders, and other physical injuries. I joined the Army at 18 after finishing year 12 where I spent the majority of my 15 year career as an MP. I have always considered myself, and been considered, as one of the boys. As a female, in striving for this I worked extra hard to 'fit in', or in my case, not stand out. In 200X I was deployed to Iraq where I was positioned at the Australian Embassy in Baghdad. We shared a checkpoint with the main casualty hospital in Baghdad, which was at the time the world's busiest Emergency Department. It was my role to search all females entering the Embassy and hospital, and to assist with the security and control access to the Embassy.

In December 200X I was confronted by a small child, no older than eight years old. She entered the checkpoint on a stretcher. She was badly injured, covered in blood and missing the majority of her legs. The young girl was followed shortly after by her grief-stricken family—her mother, father, uncles and brothers. In broken communication it was my job to tell this grieving mother that her daughter had died and she could not go through to the hospital to be by her side. She wailed, she hugged me, she hit me and she cursed. The body would later be picked up in a child-sized coffin strapped to the roof of a car.

I am now a mother of two small girls and I feel a different pain. I feel guilty and in times of panic and commotion, such as a busy shopping centre, I feel threatened that someone is lurking to take my children from me; I see the face of the father hiding in amongst people in crowded places. In addition to this was an Iraqi contractor who was shot and killed at our checkpoint. His name was Waleed; I made him a coffee every Tuesday when he came to collect our rubbish. We spoke of his wife and three children at home and that he was doing contract work to 'set them up'. He was shot and killed at our checkpoint for not stopping at a stop sign.

After returning home from Iraq I knew there was something wrong with me. I was withdrawn, not sleeping; I stopped exercising and felt socially numb. I didn't know I had PTSD but I knew I felt different. Depressed, at times scared, everything back home felt pointless to me now. Why were people whinging about the cost of petrol or that it was too hot outside? The world just didn't make sense anymore.

When I deployed with SECDET I was considered an 'attachment' to 3RAR. I had no one to relate to or 'debrief' with when I returned home. The unit I deployed with were from X. They had each other to talk too, have beers with and just generally be there for one another. I, on the other hand, was from X and I was only one of two females that

deployed on that rotation and the other female also returned to X. Instead of a normal post deployment 'down time', I was required to fit back in to my unit's routine.

As my deployment had been over a posting cycle I returned home to no familiar friends or chain of command, no family and in my case, no fiancé; he had just been deployed to East Timor. In hindsight, all huge red flags for a lack of support networks. I was granted and took some post-deployment leave with my family in X. It didn't take them long to realise that things were not great for me. I ended up in X Hospital under psych care for depression. I was released from there with my unit's knowledge under the proviso that I be referred to a psychiatrist upon return to X. When I returned to X, I was not well supported and after several trips to the RAP, my wait time to see psychiatrists was going to be six weeks. The medical staff continued to give me sick leave and send me home alone where I continued to self-destruct.

Others had been deployed and been through worse situations than me, so I thought that made me weak. My mind was racing and I was so confused. I was asking for help but no one really seemed to be taking me seriously or truly understanding my pleas. Why did my unit keep accepting my sick leave and sending me home?

I couldn't take it anymore—in 200X I drove my car into a pole, attempting suicide. The car was written off and I was admitted to X Medical Centre Hospital. I lay in a hospital bed for two weeks. Rather than it being a moment of relief and perspective, I lay there alone. In a hospital bed, with not one visitor. My unit did not tell any of my peers that I was in hospital and, as I had no one I knew in X, it only added to the shame and guilt that I felt. I felt weak and like a burden. As I was in X, I got away with not telling my family or friends what I had done. I was embarrassed. My unit at the time 'hid me away', which only added to my guilt and shame. No one was allowed to visit me or even know that I was in hospital. This added to my battle, as no one talked about it.

So this brings me on to stigma which I will go into further, but in 200X it was a huge struggle and battle for me. I fought, hid and kept this secret for almost five years, battling my way through a diagnosis of depression, eating disorders relating to PTSD and of course, PTSD itself. These were some of my darkest days, even after my attempted suicide. My army career had become a medical management plan. Fighting medical discharge, being medically downgraded and upgraded. On and off medication and pending discharge only prolonged by two bouts of maternity leave. Not until 201X when I finally broke down in my boss's office. In tears, depressed and feeling unsafe, I thought I would be open and honest and tell him that I needed to go to the RAP and get some support. He stood there with me sobbing, and instead of being a human being he told me to take a seat while he looked up the relevant doctrine to see what procedural guidelines he needed to follow. I left and made my own way to the RAP and this was the beginning of the end for me. My medical discharge was imminent.

I was, however, followed up by an email from my boss four days later stating that he had contacted the relevant 'health care professionals' and to contact him should I need assistance. Apart from being soldiers, at the core of all of us we are human beings with real human emotions, and in my opinion this gets to the real impact of mental illness. The way in which we are affected by things—our thoughts, feelings, and beliefs which may have caused our depression, PTSD or anxiety. It also can be just as powerful in the way that someone else responds to us. Empathy and understanding. Soldier-to-soldier or peer-to-peer can in our weakest moments be so empowering. Soldiers need to remember they hold a very unique bond and position and that alone, when someone is struggling, can be just enough to encourage them to seek help. So take off the rank. Sit down and put the kettle on and listen. That's all I ever wanted.

One of the biggest issues that I faced in Defence was management, particularly middle management, not knowing how to handle or deal with mental illness. The truth is, it should be dealt with no differently than any other injury. Management level Corporal through to Major need to make it 'ok' to talk about mental health. It's all well and good having processes in place, but most of these processes make people requiring them feel like they are only to be used if you are struggling or can't handle it. Programs and support should be a continued 'wellbeing approach'. Like a BFA [Basic Fitness Assessment] or a peer review. It's just something that happens. It should just become so normal that no one even thinks twice about it. Going to war is not normal—seeking support for it is!!

It is for this reason that there needs to be more open communication about PTSD and mental health in my opinion, to encourage people to talk openly about it. Make it normal 'morno' talk, not a slide show every twelve months. It needs to be personal and it needs to be real. A 'check in day' where talking about, or seeking assistance for mental health issues is normalised. I never expected people to know what I was feeling, but I did hope for some understanding. People need to feel it is normal seeking help, not the other way around.

Returning back to PTSD. I don't have a 'war hero' story. I wasn't physically injured in battle and yet I was still dealing with all of the issues associated with PTSD and mental health. These couldn't be seen and were easy to hide. This left me feeling alone and confused; 'why am I the only one affected by this?'

'I must be weak, a typical chick' and 'I can't let anyone know'.

One of the biggest problems I face is not having any physical injuries. I know that those who have them wouldn't wish them on their worst enemy, but PTSD can at times seem glorified and I say that with the utmost respect; but too often in the media PTSD is associated with being blown up by an IED or having physical injuries that result from the

trauma. For me and many people that I have spoken with, their PTSD is humanitarian based; based on what they have seen, been witness to, or a situation they couldn't prevent and they have been left feeling helpless and guilty.

I was once interviewed (in-depth) and photographed with [an army colleague] (the Sergeant engineer who lost an eye and an arm in an IED blast). He is a beautiful person and it makes me so angry to hear of his struggles but that's another story I could go on about. When the story got published it was a really lengthy in-depth story about him. Only him. Yet they used my photo. I didn't mind that the story was about him, in fact it needed to be told for his sake, but I was so hurt that they used my photo. I may as well have been his girlfriend.

I struggle too. And there are so many like me who do. I have found through my work with Soldier On and RSL Victoria that the different type of soldier plays a key role. 'Non-combat Role' soldiers find it very difficult to understand their PTSD because they often don't have physical injuries or a 'one off' physical event, like an IED or a bomb blast media-hyped stigma. They feel unworthy of the title PTSD. In addition is the combat soldier whose role it is to be 'in combat'. They see it as a weakness and struggle to admit they are struggling for fear of their peers and career progression outcomes. ADF members are proud of their jobs and like it or not, are compared to each other—well, if he and I were on the same trip and he's ok, then there must be something wrong with me. I'm weak. I'm useless. I don't want to be different. The stigma associated with not just PTSD, but mental illness. The only way it's going to get better is if more people talk openly about it.

We need a mutual understanding that PTSD is what it is and it affects everyone differently. Comparing our roles in deployment, or whether or not we are worthy of the title of 'veteran' or 'PTSD', is a huge disadvantage we are doing to each other. This has been my main struggle both in and out of Defence; dealing with the ADF and DVA and in conjunction with this, my PTSD has not always manifested typically in accordance with DVA's SOPs [Standard Operating Procedures]. As a result I suffer from extreme eating disorders, ranging from binge eating, bulimia and anorexia, and I have had to fight every step of the way to have this recognised and funded. DVA also struggle to understand that the dynamic of veterans has changed. We are younger and some of us are female.

Excuse me for generalising, but most men don't have to worry about the children as it's normally left to the wife. Well, I am the wife and I struggle daily. My children are currently in day-care four days a week because of me and that is really costly to our family. I need this time to allow me time to go to my appointments and to get through the week. When my children are at home with me, they are housebound and restricted as I lack energy and motivation to entertain them. I struggle each day trying to entertain and

keep up with them. I feel everyday that my children are suffering because of me. This weighs heavily on me every day. For me, PTSD has bought into question my parenting and I know having spoken to other female veterans, that mothering is the first thing that comes up as the greatest struggle and it's something that DVA don't even have on their radar. Children, especially young girls in my case, don't understand that their Mum isn't well, and unlike most men—and forgive me for generalising—it is not their role to keep the household running; they don't understand when Mum can't get out of bed to cook dinner or why Mum keeps crying all the time.

I'm having behavioural issues with my daughter at her first year of school and when she tells her teacher that she misses her mummy, I know that my numbness and numerous hospital visits have taken their toll; it's another layer of mothering that is not acknowledged by anyone. A final addition is a letter I wrote to the CA [Chief of Army] last year. He did respond but I heard nothing more after that.

Walter

199X–200X, ARMY Corporal. Yes, I have been diagnosed with PTSD and several friends that I have served with also suffer from it. First felt the symptoms around 200X, but attributed it to posting from Perth to Darwin. Anger started becoming frequent, no patience with my children who were both under four at the time. Went to DCO [Defence Community Organisation] for advice as it was starting to affect my marriage. DCO offered a civilian anger management course which I paid for and attended. At no stage did I tell my unit or RMO of any mental health problems as I did not want to jeopardise my chances of deployment.

After my angry outbursts which at times included emotional and physical abuse to my wife, I would be left with extreme feelings of guilt and would find myself crying for hours. I would then fall into a deep depression often for days. Personally, I was ashamed of my behaviour and would not talk to anyone about my feelings or my relationship with my wife. To this day I still feel embarrassed and ashamed to admit I have PTSD. After discharge I returned to my trade (boilermaker) and I have difficulty holding down employment.

Some leading hands and supervisors I have encountered in my various workshops have resorted to denigrating my service, drawing comparisons between being a boilermaker and an infantry soldier. Comments like 'I hope you weren't as slow in the army as you are as a boilermaker, or nothing would have got done'. Maybe they are intimidated or jealous of my service and they think that it will make me work harder or faster. I don't know, but the outcome is always the same. I ask them politely to not bring my military service into the discussion. They then think that they have found my weak spot and continue to try and exploit it. This ends with me threatening physical violence and harm upon them and then I am taken before the workshop manager and asked to explain my actions, with the leading hand or supervisors saying how I became verbally abusive with no provocation from them at all. On several occasions I then find myself being told that there is not enough work to keep me employed and I no longer have a job. In the majority of cases you are employed as a casual and the employer only has to give you four hours notice. Then you come home angry, upset and wanting to seek retribution at the person who started the whole process.

Since discharge I have had no ongoing relationship with Defence. Contact with DVA is extremely frustrating. You ring up for help and get told to refer to their website. The whole process is very complicated and without the hard work done by advocates, the claim process would have no chance of success as you do not have access to the relevant legislation and DVA's statement of principles regarding different types of injuries. DVA often sends out the wrong paperwork. I have been accused by DVA of not attending medical appointments and/or not sending paperwork back in. I have been spoken to like I

am a complete moron, with utter disregard and contempt. You are made to feel like you are another whinging serviceman out to defraud the system, or a complete bludger who has just suddenly decided to quit work and live off the system.

Several of my veteran friends have even gone as far as to lodge official complaints against the person from DVA who they were speaking to because of the accusations and degrading and insulting manner in which they are being spoken to. You get the feeling that DVA makes the whole process so complicated and drawn out that you will give up out of sheer frustration. In regards to being treated fairly, it is my opinion that DVA looks for the easy option that will save the department money. No regard for the veteran's personal and family life is taken into account. The stress of the whole process from start to finish is extremely taxing on both the veteran and their family. Often, the easy option taken by DVA results in the veteran and their advocate having to take DVA's findings and decisions to the Veterans Review Board for appeals, and the veteran being admitted to a psych hospital for further review and also to prove to DVA that your PTSD is real. The cost of this to DVA must be substantial and it seems the only party to benefit from this is the private hospital. During the veteran's stay in hospital he may be heavily sedated to alleviate the symptoms of PTSD brought on by the bureaucratic red tape.

I understand the need for checks to ensure that people are not defrauding the system, but… you spend countless hours in psychiatrists' offices reliving the events on operations that lead to PTSD, and with your wife/partner telling the psych the effect of PTSD on the family and in social interactions, and [there is] the physical pain that you live with daily due to soft tissue injuries you sustained during your service, the hearing loss and tinnitus from small arms rifles, the news that one of your mates that you served with has taken his life as he felt that was the last option because a person in DVA decides that he isn't worth a full pension and only receives $900 per month despite the medical reports saying he will require ongoing medical treatment.

I have not had a lot of contact with community organisations such as Soldier On and Mates for Mates but several of my veteran friends utilise their services and they are excellent according to all reports. I believe a solution to DVA's problems could be posting still-serving veterans to DVA as a means of respite and also as a point of contact for veterans as they can relate to the veteran making the claim; perhaps even a liaison role to offer a face-to-face meeting to discuss in a non-judgemental way how to go about your claim, and the problems that you may encounter along the way. They could advise you about the advocates that could help you make the claim and all the other volunteers there to make the process easier for you.

Appendix B

Moral injury

The following material is drawn from an interview with Professor Tom Frame. They are ideas meant to prompt discussion and to provoke debate, and represent an attempt to move beyond the familiar narrative of the 'broken' veteran being betrayed by an indifferent government bureaucracy.

The concept of 'moral injury' continues to be the subject of research and reflection but has been associated with a disturbance, disruption or diminution of a uniformed person's moral outlook and the depletion, degradation or disorientation of their moral compass as a consequence of operational service. A morally injured person will question the validity and necessity of moral values; chastise discontinuities between the idealised moral self and the realised self; and, wrestle with assertions of universal moral logic.

Moral injury is 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 manifested in personal guilt and shame, or indifference to human pain and suffering—without the causal event being traumatic. Moral injury does not flow from external stress, but from internal reflection. It has to do with what a person makes of what they see, hear, smell, touch and taste. Two people can experience the same thing: one will be unaffected, while the other will be injured. The difference is how they interpreted their experience in terms of the value structures ordering and regulating their inner being.

The usual narrative (echoed by both the media and the parliament) runs as follows: 'these young men and women have served their country faithfully and well. Defence has broken them in body and mind and DVA has failed to look after them adequately. Something needs to be done. We (those indicted are never completely defined) have failed these veterans and the system is broken'. Against this backdrop, PTSD has found its way into the popular imagination as the accepted description and the agreed phenomenon that captures the experience of so many who have been negatively affected by their uniformed service or operational deployment. This narrative is highly problematic in a number of ways.

Problems with PTSD itself

All negative experience resulting from a military career is not usefully described practically or conceptually as PTSD. The term 'moral injury' may explain some negative fallout, but there may be a myriad of other useful ways to understand the effects of military service on

the human mind. PTSD has become the 'catch all' complaint for anyone working in emergency services, including the police. It is not specific to the ADF and yet, curiously, its operating parameters are very different in the non-Defence community. Hence, the importance of research into moral injury. PTSD is not well explained (it is described, more than defined), and suffers from an unstable diagnostic foundation (witness changes in the definition between DSM III, IV and V). Its application by the profession of psychology reflects an almost complete reliance on this branch of behavioural science at the expense of multi-disciplinary approaches. Routine 'diagnosis' of PTSD appears to facilitate, if not encourage, compensation claims where the disorder is worsened by the process of litigating unsuccessful claims. The goal here is not to absolve the government of responsibility, but to broaden the conversation about what that responsibility might look like. Rather than deny culpability, the discussion could instead turn to how best the military can meet the challenge of looking after its people.

The need for a realistic narrative on military 'service'

Given the messages conveyed in recruitment advertisements and the way in which newly-joined personnel are encouraged to see a deployment as a career highlight and the chance to validate their training, the military may be encouraging a mindset that resembles that of state-sanctioned mercenaries where career-minded individuals believe going to war will offer personal/professional development opportunities rather than primarily serving a noble cause—the defence of the nation and its people. A career in the military is depicted as a personal challenge, not service of the common good. War is no longer about protecting Australia or serving our nation; professional soldiers receive a generous deployment allowance and medals in exchange for the work they have done. Their service is voluntary and they are remunerated on the basis that they are on deployment. In essence, increased allowances are the 'pay off' for accepting increased danger. This is what the DFRT [Defence Force Remuneration Tribunal] determines. It may therefore be helpful to formalise the 'assumed' moral contract of service. For example, the UK Government has a 'covenant' between the state, the nation and the armed forces to make explicit the relationship between society and the service person, setting out obligations and responsibilities on both sides.

Limitations of the entitlement narrative

An entitlement mentality, visible well beyond the uniformed community, where every element of human interaction is potentially susceptible to compensation, will deplete social capital and destroy communal solidarity. In the context of uniformed service, regardless of the outcome of a 'DVA battle', it will not replace the next phases of life with the support of

family and friends and community, and taking responsibility for oneself. A more realistic attitude to a military career and a degree of frankness about its character, coupled with a willingness of recruits to prepare themselves and take responsibility for what happens, may create the circumstances where an injured person is more likely to be healed. Refugees have often experienced horror, but their lack of a feeling of entitlement means they work hard and build lives for themselves. They were, and are, animated by a different narrative—they are not victims, but survivors whose experiences have strengthened rather than depleted them—for the greatest part. With enough retelling of a story, it has a way of becoming reality. The problem may not be PTSD; it may be that an individual is angry and bitter in a way that is not fully known to themselves. This only highlights the need to create a positive and productive narrative.

Nor does the 'slipped through the cracks' narrative explain the situation. At what point can the state intervene in a preventative way when someone has chosen to self-exclude. In a voluntarist society which remains sceptical of state intervention, personal help is sought and not imposed. The issue here is that neither society nor government can prevent all harm; the narrative of the 'government needing to do something' is part of the assumption that whatever happens to an individual, it is eventually and ultimately the responsibility of the state. Whereas, in reality, individuals need to prepare themselves for life and accept the need to respond personally to the challenges associated with everyday living. The state cannot provide what an individual declines to provide for themselves. The nature of the relationship which exists between the state and the individual is clearly at issue. Yet, it is rarely discussed. We are somewhere between the UK and the US when it comes to defining the essential elements—somewhere between covenant and contract.

Appendix C

Rural Fire Service model—Paul Patti, veteran advocate

The following proposal was put together by Paul Patti, a retired senior Army Officer and now Canberra-based veteran advocate and business owner. His proposal is that the Rural Fire Service be used to provide a sense of community and mental health support to ex-serving personnel.

> The ADF community is culturally diverse and physiologically profiled as a group that needs firm, confident tribe and family leadership towards treatment. The ADF community is a service-oriented structure and former members comment on the significant personal security they derive from this. My working hypothesis therefore is that mental health support could most effectively be delivered by an organisation that is compatible with this service orientation. The Australian Rural Fire Service (RFS) is a nationally-based service-oriented structure that has credibility akin to the ADF and surety of ongoing relevance in the Australian community. The RFS has a depth of membership roles mirroring the ADF, is mentored, and lead by a mature, effective and action-oriented leadership. The RFS has an embedded mental health support and counselling action plan in place which has been tested and shown to be successful, has funding in place, and is regionally delivered. All the elements of a compatible culture are present, including the service orientation of the RFS, its real world community mission, and pre-existing mental health action plan.
>
> As veterans recover, they could be invited to join their local RFS unit in a capacity that serves their community. There are obvious benefits for both parties within this proposal. The RFS gains a highly-skilled, motivated and loyal membership, while veterans gain an accessible treatment source, membership of a new tribe with a real world focus and mission. Additional benefits include:
>
> - budget neutral
> - not just a health solution—a whole-of-community solution
> - fast-acting
> - long-term
> - nationally effective and
> - potential for bi-partisan support.

Appendix D

From: Parliamentary Librarian (DPS)
Sent: Tuesday, 23 June 2015 4:28 PM
To:
Subject: Mental health of military personnel

Dear _____

As you may be aware, this year's Australian Parliamentary Fellow, Dr Edward Scarr, is researching the topic of *The 44th Parliament and the mental health of military personnel and veterans: Attitudes, beliefs, intentions*. This represents an issue in national politics that is of considerable significance and interest to the Parliament and the broader community.

I am writing to ask if you would consider sparing some time to meet with Dr Scarr to discuss his research. He is particularly interested in interviewing you, as you have either served in the military yourself and/or have addressed the Parliament on this topic. Dr Scarr would be grateful for an opportunity to explore your exposure to the issue of veterans' mental health in your role as a parliamentarian. Your perspective would be very useful and should only take 15–20 minutes. Dr Scarr would be happy to talk to you on the phone if this was more convenient than a face to face meeting.

Information obtained via interview may be published by the Parliamentary Library as a component of the 2015 Australian Parliamentary Fellow monograph. Interviews will not be recorded and all responses are confidential, non-attributable and will only be presented as aggregated data.

Dr Scarr will be in contact with your office shortly. However, should you have any questions about the project, please don't hesitate to contact me.

Yours sincerely

Dr Dianne Heriot Parliamentary Librarian

Parliamentary Library

Department of Parliamentary Services

Abbreviations and acronyms

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
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	*Military Rehabilitation and Compensation Act 2004*
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
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	*Safety, Rehabilitation and Compensation Act 1988*
TBI	Traumatic Brain Injury
TGA	Therapeutic Goods Administration
TSES–R	Traumatic Stress Exposure Scale – Revised
VEA	*Veterans Entitlements Act 1986*
VRB	Veterans Review Board
VVCS	Veterans and Veterans Families Counselling Service
White Card	DVA Health Card – for Specific Conditions

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