THE RETURNED & SERVICES LEAGUE
OF AUSTRALIA LIMITED
NATIONAL HEADQUARTERS ABN 63 008 488 097

FOUNDED
IN 1916

From: Rear Admiral Ken Doolan AO RAN (Retd)
National President

23 June 2015

Mr David Sullivan
Committee Secretary
Foreign Affairs, Defence and Trade Committee
Department of the Senate
PO Box 6100, Parliament House
CANBERRA ACT 2600

By Email: fadt.sen@aph.gov.au

Dear Mr Sullivan,

Inquiry into the mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment.

The Returned & Services League of Australia (RSL) welcomes the opportunity to forward a submission in relation to the Senate's Foreign Affairs, Defence and Trade Committee's inquiry into the mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment.

This submission was formulated by the RSL's National Veterans' Affairs Committee.

Attached is also a submission from the Director of Homes for Heroes at RSL LifeCare.

The RSL welcomes attendance at any public hearing of the Committee to elaborate or answer any questions regarding these submissions.

Yours sincerely,

Attachments: RSL National Submission
RSL LifeCare Homes for Heroes Submission

LEST WE FORGET

G.P.O. BOX 303
CANBERRA
A.C.T. 2601
PH: (02) 6248 7199
FAX: (02) 6247 7637

FOUNDED IN 1916

ENCLOSURE 1

THE RETURNED & SERVICES LEAGUE OF AUSTRALIA LIMITED

Senate Standing Committee on Foreign Affairs, Defence and Trade

Inquiry into the Mental Health of ADF Personnel

SUBMISSION
BY
The Returned & Services League of Australia

Preface

Before addressing the Terms of Reference for this Inquiry it is essential to consider the National Mental Health background of the Australian Community in which these actions are taking place. The Australian Defence Force (ADF) is a concentrated body of men and women working in close association and sometimes under difficult circumstances; they are at the same time, citizens within a larger community from which their original backgrounds and upbringings are derived.

Despite the physical, and mental health standards that are required for entry into the ADF there are religious and family attitudes associated with upbringing that pervade personality as well as personal assessments towards what are acceptable standards of behaviour. These cannot be accounted for in the ADF's current, routine, admission selection process.

At the present time, in our Nation at large, the following unsatisfactory points are important to keep in mind when discussing any forms of mental health assessment, treatment and care:

- A significant lack of access to services involving both prevention and care.
- A lack of co-operation across sectors within the Mental Health Care Sectors.
- Human rights issues including, for example, the necessary privacy of information and such blanket actions as placing all those who are heavily intoxicated in jail cells when Accident and Emergency may be more suitable.
- Gaps in mental health training of personnel both medical and nursing
- Documentation of people in the system and the collation of relevant data.
- People not seen until a crisis occur when symptoms alone should have been sufficient to alert the need to act.
- Services should be based on need not on diagnosis
- The funding from closed Mental Health Hospital facilities has not reappeared in the community health system.

So it is against this already complex National Mental Health outline of the present community's difficulties that we must consider the issues identified by the Senate Inquiry's Terms of Reference. Consistently present in the background of our thinking must remain the following refrain of Professor Patrick McGorry's, "Mental Health spending is not a cost but an investment".

The World Economic Forum recently demonstrated that, of the major non-communicable diseases, mental illness is the most important threat to economic prosperity. The neglect or inadequate care of the mentally ill, many in the prime of their working lives is a waste of human resources.

Further to the above the National Mental Health Commission chaired by Professor Allan Fels AO released a massive review of our Mental Health System in this country (April 2015) and this contains the following relevant facts to add to our general community's mental health background:

- 60% of Commonwealth mental health spending is on income and disability support payments
- 3.6 million people each year experience mental health problems
- 50% of Australians experience mental health problems in their lifetime. Only half get treatment
- The gap in life expectancy for people with a psychosis is between 14 and 23 years less than average, largely due to heart and other health problems.
- In 2012 more than 2500 people committed suicide.
- 42% of people shot by police in the last decade had a mental illness.
- Australia is second in the OECD (The Organisation for Economic Co-operation and Development) for antidepressant consumption.

As an introduction to this inquiry, Defence is well known as a high risk occupation. It is physically demanding and involves exposure to disaster, war and some of the worst situations most of us can imagine. Despite rigorous training and selection, some people will be injured and some will suffer mental ill-health as a result. Although the current generation of service men and women serve only an average of six years, they often join the service after they leave school and serve on multiple deployments.

The nature of the job means that they are often separated from family and friends for extended periods and may live in several locations around Australia during their Defence career. Some Defence members also cannot disclose the true nature of their work to others.

The result is that Defence members and their families often socialise primarily with other Defence families, feeling more comfortable with others in similar circumstances. This can limit their ability to form meaningful relationships outside Defence.

These factors can become future barriers to accessing help post-discharge and in times of need.

Understanding the unique nature of Defence employment and its impact on family is important to understanding reactions to symptoms of mental ill-health and Post-Traumatic Stress Disorder (PTSD) both during and after Defence service.

In relation to PTSD, we are aware of current research into the physiological responses to PTSD and how they may explain why one person is affected by PTSD and another is not. Whether or not this research will ultimately allow effective screening for susceptibility to PTSD or some sort of preventative treatment is important for the future, but should not divert attention from those suffering now.

The Returned & Services League of Australia (RSL) supports research into effective treatments for mental ill-health and PTSD. Specialists such as Dr David Forbes from Phoenix Australia, the Australian Centre for Posttraumatic Mental Health and Professor Zachery Steel from St John of God Hospital tell

us that 30% of people do not respond to current treatments and there is clearly more work that needs to be done in this area.

Whilst help for the veteran is vital, it is only part of what is needed.

Mental ill-health affects more than just the individual – it can have devastating effects on family and friends. If we are to help the individual, we need to understand the broader impact of the condition and identify the support needed to give the individual and those directly affected (such as partners and children), the best chance for recovery or ongoing management of the condition.

Anecdotal evidence and case histories of hundreds of veterans and their families telling of similar experiences with service-related mental ill-health are compelling. The link between mental ill-health and military service is clear given the rise in successful claims with the Department of Veterans' Affairs (DVA).

While organisations like the RSL reach out to those we know of in need, the reality for many is that early symptoms are ignored.

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

Ignoring symptoms and not seeking help can typically go on for eight to 10 years after discharge. Failure to respond to early symptoms can result in a progressive downward spiral towards family and relationship breakdowns, bankruptcy, homelessness and tragically, suicide.

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

However, relying on informal networks alone can be fraught with potential problems.

There is no doubt that in the past some well-meaning veterans (mainly volunteers and themselves suffering) have hindered rather than helped veterans and their families in trouble.

This is changing.

TERMS OF REFERENCE

A. The extent and significance of mental ill-health and post-traumatic stress disorder (PTSD) among returned service personnel.

The measurement of the extent of these disorders is often quoted by our own Joint Health Command (JHC) as being of the order of 8.3% within the ADF as a body of men and women. This figure is misleading in a number of respects, particularly when it represents the entire armed forces and not just those recently returned from overseas.

Canadian figures, when examined, show the following in a 2013 survey asking sailors, soldiers, airmen and airwomen whether they had experienced one of the following six conditions in the past year (depression, PTSD, generalised anxiety disorder, panic disorder, and alcohol abuse or alcohol dependence):

- Approximately one in six Regular Force members of the Canadian Armed Forces (16.5%) reported symptoms consistent with at least one of five selected mental disorders in the 12 months prior to being surveyed. Of the five disorders measured were depression was the most common disorder, with 8% of Regular Force members reporting symptoms in the 12 months before the survey;
- Regular Force members who had been deployed in support of the mission in Afghanistan had higher rates of mental disorders than non-deployed members. The rates of post-traumatic stress disorder and panic disorder were twice as high among Regular Force members who had been deployed compared with their non-deployed counterparts;
- In addition, the Canadian researchers found about 19% of returning service members report they experienced a possible traumatic brain injury while deployed, with 7% reporting both a probable brain injury and current PTSD or major depression.

We must be mindful that figures are affected significantly by a number of other factors:

- Duration of time away from the area of combat;
- The coaching many service personnel receive from fellow soldiers to avoid admission of symptoms when examined;
- The intention to leave the ADF soon after returning from MEAO;
- Substance abuse which may cause discharge on disciplinary grounds, and there is no discussion of any background mental health issues;
- If there has also been a co-existent medical problem with concussion or blast injury whose symptoms can mimic those of PTSD; and
- The requirement to fulfil the Diagnostic and Statistical Manual of Mental Disorders (DSM) V complete psychiatric diagnostic requirements before a formal diagnosis can be made. A very common reason for the late onset of initial care.

The *U.S. National Vietnam Veterans Readjustment Study (NVVRS)* found that the lifetime prevalence of PTSD in Vietnam Veterans was 18.7%. The study also showed that PTSD was not explained by a desire for compensation but an accumulation of exposure to the burden of warfare confrontation. The Canadian figure for their veterans being released from service for the period 2011 – 2016 is predicted to be 20%.

The Australian Centre for Posttraumatic Mental Health (ACPMH) in 2015 stated, "20% of serving personnel have a mental health disorder and of those, PTSD is the most common. In addition we know the disorder's symptoms continue to grow and expand over the ensuing five to eight years after discharge if treatment and care are not commenced promptly", Professor David Forbes – Director.

It is important to be mindful that mental health issues are not restricted to those who have served abroad in operational circumstances. The symptoms and the full syndrome of a number of mental health DSM V registered complaints can occur as a result of bullying, bastardisation, sexual harassment, as well as the concerns of training and the dangers entailed therein. The latter may in turn have a compounding effect with operational time abroad when the latter effects alone appeared to be minimal.

In addition it's important to remember that the earlier a member with a mental health complaint can be seen and commence therapy the sooner the issues can be potentially resolved. To succeed in this

area individual members must be encouraged to seek assistance when any difficulties first appear that are worrisome. To be forced to wait for the full list of diagnostic criteria to be met (see DSM V) before any ailment warrants valuable care, is a medical degradation. The *Repatriation Commission Determinations 19/2000* and *23/2000* specifically state:

- Veterans and other members entitled under the VEA who suffer an unidentified condition (a medical condition that does not satisfy diagnostic criteria in current evidence-based medicine); and
- Veterans and other members entitled under the VEA suffering an anxiety or depressive disorder are entitled to non-liability health cover (ie. treatment and care).

This must equally apply to currently serving members of the ADF. It is too easy to be dismissive when the practitioner has a low index of suspicion in the presence of a reluctant patient. Too much is being missed in the early stages of mental health issues from not looking and questioning as opposed to not knowing.

The significance of mental ill health can be seen from Professor Philip Clarke's large study of Vietnam Veterans released in March 2015. The study, the largest of its kind, found that military personnel deployed in Vietnam were 23 times more likely to be suffering psychological problems such as PTSD than personnel who were never deployed, and that the longer they were deployed the greater the incidence of disability in the future.

Lead author Philip Clarke of the University of Melbourne said the eventual high rates of disability should be a wake-up call to the community. "Clearly the government needs to have lifelong frameworks in place for caring for veterans on their return," Professor Clarke said. "When the government commits troops to war, it becomes an extremely long-term decision and I don't think the Australian community is fully aware of that."

If we look at the top 20 accepted conditions by the DVA for all operations since East Timor, the numbers for PTSD and depressive disorders grew by 30% each year in the two years to September 2014. Anxiety Disorder and Adjustment Disorder have also entered the top 20 conditions in the *DVA Annual Report 2014*.

Whilst the growth in DVA claims for mental ill-health and PTSD in recent years may appear inconsistent with published ADF survey results, this may be explained by some key issues derived from anecdotal evidence from veterans and their families as follows.

- While in the ADF, veterans' fear of being medically downgraded leading to medical discharge and the loss of their career is a reason why many refuse to seek help or acknowledge the early symptoms of mental ill-health;
- Veterans can become increasingly adept at hiding symptoms to the point where they convince not only those around them, but themselves, that they don't have a problem;
- Symptoms of mental ill-health for some veterans can first appear or become progressively worse post-discharge. In many cases, veterans delay seeking treatment because of reasons that include pride, a belief that they don't have a problem and a lack of understanding of the severity of the symptoms;
- The RSL's experience is that the partner often reaches out for help when the relationship has deteriorated to breaking point, forcing the veteran to act and this often occurs years after discharge;

- The increased awareness and reduced stigma of mental ill-health and PTSD in the community may be helping some veterans reach out for help after they have left the service;
- Many service personnel accept some of the symptoms of mental health issues as normal and not necessarily early indications of PTSD or other mental illnesses. Discussions occur among service personnel where comments include such things as 'everyone has nightmares'. The belief that symptoms are normal could deter service personnel from talking to medical professionals, reducing the possibility of early treatment and potentially affecting outcomes. It may also influence their responses to ADF surveys, regardless of whether the surveys are anonymous;
- Partners of veterans consistently report that their veteran partner has experienced years of increasingly severe mental ill-health symptoms. The pattern is a progressive withdrawal from family and friends, often to the point of a total breakdown in relationships and sometimes homelessness prior to seeking help. Sadly some veterans take their own life instead of seeking help;
- Some veterans report that they initially believe (sometimes for years) that they are 'not the problem' - it was 'everyone' else. Some don't lodge a claim for service-related mental health conditions until after a total breakdown and then only when forced to do so by their partner;
- Some veterans report to varying degrees that they are hyper vigilant and their learned responses in Defence remain 'locked on', even after returning from a conflict and in a relatively less dangerous situation;
- A number of veterans have spoken of the intensity and length of their initial training in Defence compared with the much reduced two-day transition seminar when leaving. Veterans report transition experiences ranging from positive and successful to poor. Successful transition appears to be often linked to a mentor or individual in Defence who is encouraging, helpful and at times forcefully encourages the veteran to actively engage in the process and complete the necessary tasks prior to discharge; and
- A number of online veteran's resources have started to monitor known veteran suicides in recent years. Sadly, suicides due to car or other accidents are unknown. DefenceCare has a number of clients who have attempted suicide or exhibited suicidal behaviour on a number of occasions.

Senator Michael Ronaldson, Minister for Veterans' Affairs, reports that DVA clients number approximately one in five of all Australians who have served in the ADF. Using DVA's approximate current client numbers of 330,000, this means the potential number of veterans suffering service-related mental ill-health could be significantly higher than those who have lodged claims.

As ex-serving members are not compelled to register with DVA unless they want to claim for a service-related injury or illness, the extent of mental ill-health among ex-serving men and women is unknown. Given the typical presentation some eight to 10 years after discharge and the experience following the Vietnam War of delayed onset of symptoms, it is highly likely that there are a significant number of veterans with service related mental ill-health who are as yet unknown to DVA.

The lack of accurate information in this area is concerning but the sheer numbers of veterans seeking RSL support alone is enough to indicate that this is a severe problem.

B. Identification and disclosure policies of the ADF in relation to mental ill-health and PTSD

The identification and disclosure policies are laid out in the ADF policy document *ADF Mental Health and Wellbeing Plan 2012-2015*. These priority actions were informed by the findings of the *2010 Mental Health Prevalence and Wellbeing* study and by the *Dunt Review 2009*.

The following are listed as this document's Priority Actions:

- Addressing stigma and barriers to care
- Strengthening the mental health screening continuum
- Improving pathways to care
- Developing e-mental health approaches
- Developing a comprehensive peer support network
- Enhancing service delivery
- Up-skilling service providers

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

There is no doubt that Defence supervisors, officers and medical practitioners have a key role to play in helping identify serving members experiencing symptoms of mental ill-health and ensuring the safety and optimum performance of their teams. Unlike other employers, there is the added complexity of their unique and hazardous workplace and the potential risk to others.

For many Defence members, mental ill-health leads to medical downgrading and eventual discharge. The potential loss of their career and concern for their own and their family's future, can be devastating. Fear of being seen as a failure and being unable to provide for or contribute to the family can weigh heavily and cause added distress.

The issue of identification of members with mental ill-health, especially in the early stages can be difficult. Members are well aware of the financial incentives associated with deployment and the need to be physically and mentally fit to deploy.

The RSL is aware that some members do not disclose symptoms to avoid medical downgrading and remain ready for overseas deployment.

Defence members also know that discharge can be a consequence of disclosing mental ill-health and this is also a deterrent to coming forward for treatment. Unfortunately, this can be the start of an ongoing pattern of deception, withdrawal from relationships and decline in health and wellbeing of both the veteran and their family.

Gaining an accurate picture of the extent of the 'hidden' mental ill-health and the average length of time from the first onset of symptoms until disclosure would be valuable, but is probably difficult to obtain.

Dr Andrew Khoo said in a recent 4Corners program on PTSD that in his view, encouraging Defence members to seek early medical treatment for mental ill-health will not be successful until Defence allows members to be treated and continue in their career with Defence. Until then, serving members will continue to believe disclosure of mental ill-health will threaten their Defence career.

C. Recordkeeping for mental ill-health and PTSD, including hospitalisations and deaths

In general terms this portion of the mental health care crisis is a reflection of the National care problem as well.

When death occurs as a result of self-harm in association with existing mental health difficulties, unless it is very clear, e.g. self-inflicted injury or overdoses, then the cause of death is very often left open by the coroner. This action produces inaccurately low figures with regard to suicide figures particularly when substance abuse, motor vehicle accidents and cliff falls are involved. In addition there may be no mention of a mental health history on the death certificate at all.

At present too many primary health care consultations do not enquire about former employment and military service when taking a medical history, just as veteran status may not be mentioned in a hospital or detention centre's admission forms. There are exceptions but it's not the rule. There is also no ADF service mentioned on death certificates in any state record keeping. These statistics are non-existent sadly.

The need to continuously repeat a mental health history to every new practitioner encountered can prove counterproductive in itself. Often the patients will be reluctant to repeatedly go through the exercise per se. With the introduction of the Personally Controlled eHealth Record (PCEHR) in the near future this may become less of a problem but hospital care and treatment information rarely accompanies the patient in a timely manner post-discharge, particularly in the case of an acute admission.

There remains much room for improvement in this communication area for the general public and service personnel alike.

D. Mental health evaluation and counselling services available to returned service personnel

While the member is undergoing evaluation and counselling so must the other family members involved, depending on each separate set of circumstances. So listing what the member has available must similarly apply to everyone associated with that person. This silo thought process of care must cease. While still within the ADF and on returning home from combat and peacekeeping operations there are six key initiatives JHC endeavours to address:

- Integration and Enhancement of ADF Mental Health Services;
- ADF Mental Health Research and Surveillance;
- Enhances Resilience and Wellbeing in the ADF;
- ADF Critical Incident Mental Health Support;
- ADF Suicide Prevention Program; and
- Alcohol, Tobacco and Other Drug Program

Having the programs in place and maintaining a high measurable standard over a wide geographical distribution of usage has proven extremely difficult for JHC to accomplish. JHC's principal problem is to encourage members to come forward early to discuss what is going on with their personal mental health.

There are important figures produced by the Australian Centre for Posttraumatic Mental Health (ACPMH) when discussing mental health. If taking only one aspect, PTSD, we need to consider the following:

- Of the military personnel deployed between 2002 and 2009, almost 2500 suffer from PTSD;
- Only one third of people with PTSD will gain a full recovery using current treatments;
- Mental Health Programs for Veterans currently cost the Australian taxpayer $166 million per year;
- From 2010-2013 the number of mental health claims by contemporary veterans rose by almost 200%;
- 20% of serving personnel have a mental health problem;
- PTSD is the most common mental health disorder.

The RSL supports the following ACPMH recommendations:

- An Australian research centre to discover new treatments for PTSD and other military related mental health problems
  - Systematically address gaps in knowledge
  - Test innovative treatments
  - Enhance treatment effectiveness
  - Focus on early intervention
- A national practitioner support service, grounded in evidence-based research, to provide support to practitioners working in the field of veteran and military mental health
  - Provide advice and guidance on the treatment of complex mental health problems in veterans and military personnel
  - Ensure effective treatments are widely available
  - Support practitioners to use evidence-based treatments
- There is an urgent need to learn more about PTSD and its related mental health problems and to develop new and more effective treatments
- The best treatments currently available only work for some and only a third of PTSD patients fully recover. Systematic research is needed to address the gaps in our understanding, test innovative treatments, and discover how to improve treatment effectiveness
- Practitioners in the community need advice and guidance from experts in veteran and military mental health in order to successfully treat these complex problems.

Currently, effective treatments are not widely available, and only a limited number of people in need receive the best treatment. It is particularly important that we reach rural and remote Australia where many veterans and their families live:

- The Centenary Institute of the Melbourne ACPMH will for example provide far-reaching benefits for Australia's veterans and their families
  - Saving lives. By reducing the burden of PTSD on veterans and their families, the risk of suicide and other risk-taking behaviour will be reduced
  - Rebuilding lives. Better mental health, reduced disability, and increased productivity and capacity to work, will enable veterans, their partners and their children to rebuild their lives
  - Reducing suffering. By improving mental health treatment, veterans and their families will be freed from the ongoing and far-reaching impacts of PTSD
  - Reducing costs. Effective treatment will reduce the otherwise high healthcare costs to individuals and society of mental illness in general, and PTSD in particular

- Increasing knowledge. By addressing the current gaps in evidence-based treatments for PTSD, sufferers around the world will benefit

The Government must be prepared to make this financial undertaking towards the outcomes listed above and not consider it a costly outlay with no long-term benefit but as a long-term capital saving investment.

The institutions to do this work exist already in three states, Victoria, NSW and South Australia, plus they all possess international reputations in their own right. However, without the required funding, future governments will pay dearly and for a very long period of time because of the debilitating mental health problem within our Defence and the general community. Any beneficial military experience in care will be passed on immediately to the general community as well.

In the collection of Mental Health Resources information available on the ADF web site there is nowhere to be found a simple explanation of what real relevance this mental health exercise has for any particular ADF member. Why does it matter to them? The age-old question of "What's in it for me?" now or later on, sadly receives no attention anywhere at all.

E. The adequacy of mental health support services, including housing support services, provided by the Department of Veterans' Affairs (DVA)

Mental Health support services

The Veterans and Veterans Family Counselling Service (VVCS) programs are available for partners and families. However:

- There are ex-service persons who do not access DVA or VVCS supports/programs as they feel they are not entitled – as such partners and families do not know they can access, including:
  - those with rejected DVA claims
  - those who did not have operational services, particularly peace keepers
  - those who have not ever applied for any DVA entitlements

- There is differing knowledge between the ex-service cohorts (age groups) of what programs/supports are available, more promotion of entitlement to supports/programs is required
- The limitations on eligibility based on the age of veterans' children need to be removed. The children of Vietnam Veterans are eligible to access VVCS programs for life; however children of other conflicts/service are only eligible to access until they reach 26 years of age
- Multiple deployment syndrome is a reality and thus will have an effect on partners and families; it is imperative that the age limitations placed on the children are removed – need to ensure that the children of all veterans/peacekeepers/service persons who are eligible for VVCS can access these programs for life.

There needs to be more promotion of the programs/supports available to partners, carers and families. While there are numerous excellent resources available, the majority of time the treatment and support is very focused on the veteran and not on their significant other/family. So while there is support, partners/families are not always aware of what's available nor do they know how to access.

There remains a considerable lack of emphasis on prevention with respect to mental health issues. For example, with the recently released *High Res App* the following is written, "Test your physical, cognitive, emotional and behavioural reactions to stress and adjust your response in real time by using the stress management tools in the app. Optimise your performance and build your psychological resilience and mental fitness with regular resilience training". There is no reason or incentive provided to use this equipment. Members between the ages of 20 and 30 years will fail to bother because to their way of thinking, it doesn't apply to them. It's not a stigma thing it's a "Why me thing?"

We must articulate our reasoning to them so we can work together so our purpose is clearly understood by them. Having a 'care plan' does not in fact mean that care is being provided. Children are taught how to swim so they will not drown. Therefore members should be similarly taught how and why they require resilience training in order to avoid mental health difficulties with the passage of time. There is no shortage of examples.

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

The RSL would support the extension of non-liability mental health support to all who have served in the ADF.

Housing support

The provision of housing support per se is non-existent.

It is acknowledged that DVA's *Crisis Assistance Time Out* program can be arranged day or night and provides a member with short-term accommodation for up to five days. This gives time to seek the assistance of VVCS to address the problems that resulted in homelessness and to rebuild relationships with family and/or community.

As this service is unsupported, VVCS is unable to assist those who:

- have a substance abuse problem
- are at risk of self-harm
- have violence issues

VVCS may be able to assist people with such problems if they have an appropriate support network in place, such as a homelessness sector case manager. Short term arrangements can be made up to five days but it will basically be the ESOs that will provide any assistance and this will be very patchy at best.

The Committee's attention is drawn to the RSL LifeCare's Home for Heroes submission for more detailed information, recommendations and case studies (Encl 2).

F. The support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD

The factor of support availability cannot be examined in silo like isolation. There is a requirement for a 'team of teams' approach where the individual member is accessing care. There will need to be others supplying care for partners, parents or spouses and yet a third group of professionals doing the same for younger family members. These are three very distinct groups of individuals and the approaches to all three are by their nature quite different while still seeking the same harmonious outcome for a particular family unit.

The member's experience is conflict driven while those of the adults are derived from an interaction with that individual. The children may have a similar interaction derivation. However, there can also be an additional epigenetic factor in its origin if children were conceived post-conflict. There remains much research work to be done in this field of Defence children and their mental health.

In the beginning success is dependent on the individual member seeking and gaining professional help, while still in the ADF as a regular or reservist at the time symptoms first manifest themselves. Waiting until after discharge introduces a whole range of difficulties that could have been avoided with much earlier care. These include but are not restricted to: medical records, incident witnesses, exposure to blast injury factors and loss of moral support mechanisms provided in their working environment.

The RSL is aware that there are considerable concerns surrounding the support available for partners, carers and families of returned service personnel.

An RSL NSW led Carer's Forum was held at DVA Sydney office on 25 - 26 June 2014. The forum brought together carers and partners of veterans of recent conflicts who had an accepted disability of mental and/or physical injuries, to hear about issues that they face in their role.

The Forum was attended by nine spouses and three parents and was supported by RSL NSW and VVCS specialists. The forum allowed them to share their experiences, identify issues of concern and discuss the value of creating local support networks where carers can come together and help each other.

Some of the key issues raised at the forum included the following:

- A lack of information for carers about the veteran's condition, how to best manage their condition at home and the services available to support them and the veteran. In particular, carers commented about the veteran's inability to understand and interpret information and the need for the carer to be more actively involved in liaison and advocacy
- Difficulties in relationships with the veteran and the need for mental health supports such as counselling, peer support and workshops
- For parents who are carers, concerns over who will take care of the veteran when they are no longer able to do so
- For families with children, the impact on the children, the need for support for children and recognition of the children's needs.
- Relief from the constancy of caring and the feelings isolation, exhaustion and chronic sorrow
- Health support for the carer as they can also suffer trauma and have symptoms that mirror those of the veteran.

Participants also discussed the services that they felt would minimise the impact of living with a veteran with mental and/or physical illness. These included practical help with hygiene, physical

neglect and safety in the home; counselling for the carer, veteran, couple and family; and peer support groups. Other areas addressed were:

- the financial impact of the service-related injury or illness,
- the often hastened departure from Defence and sudden loss of support networks and housing,
- legal issues associated with relationships, powers of attorney, guardianship, superannuation and finances,
- the need for resilience building in the family to cope with the trauma,
- inadequate separation planning from Defence, and
- transition support for those medically discharged as well as their family members.

One of the key learnings was that enhanced outcomes for veterans with mental and/or physical injuries were linked to the support received by the carer and in this sector, the support is insufficient.

Discussion of Forum participants' experiences and challenges and documented RSL NSW counselling records suggest that the physical and mental health and family and marital relationships of carers of contemporary Australian veterans are severely compromised.

Interestingly, some carers report that when they approach some government and non-government organisations, they are told to approach DVA as they are caring for a veteran in the mistaken belief that DVA provides services for carers.

From the carers' reports, it was clear that there was mirroring of the veteran's psychological symptoms (hyper-vigilance, anxiety, depression, anger, frustration, social isolation). Domestic violence and controlling behaviour were being endured by carers and children. In addition, parents and partners of veterans reported having to give up their career/jobs to look after the veteran or take so much leave without pay for this purpose, that they were experiencing financial hardship. A major issue for the parents caring for their veteran son was the son's suicidal ideation/attempts following the breakup of their marriage, and loss of access to their children.

The Forum highlighted gaps in support for carers and the need to develop a comprehensive peer support program that would provide sustainable support that would complement formal mental health services.

Following the forum, representatives of RSL NSW and DVA met with stakeholders and reviewed literature surrounding support for carers.

This highlighted that the plight of carers of veterans with substantial mental and/or physical injuries is critical with many at breaking point. There are significant immediate and long term health risks to carers if assistance is not forthcoming, especially the high risk of developing depression and stress related illnesses. Poorer health outcomes and slower recovery rates for veterans are likely to be the result of carers' lack of adequate and appropriate supports, incapacity to cope, and lack of knowledge of services. Risks of family/marital breakdown will be increased.

Interventions that can assist children who are young carers of contemporary veterans with mental health issues will help prevent the risks of mental illness, substance abuse and high suicide rates later in life, and help maintain academic performance and school attendance. These factors were noted to be characteristic of the sons and daughters of Vietnam veterans due to the impact of living with a parent with significant mental health issues such as PTSD, anxiety and depression and the unavailability of support and counselling services for more than 20 years post the Vietnam War era.

As a result of this forum, a business case based on both the forum's results and established research on peer-to-peer support networks, was prepared and recommends a two-year trial of a Peer-to-Peer support program initially run in NSW and involving the appointment of a Peer-to-Peer Coordinator. The proposal involves working with Carers NSW and ARAFMI (two organisations already supporting carers in NSW) to establish Defence-specific support networks for carers.

The estimated cost of a two-year trial is $380,525 ($174,315 in year 1; $206,210 in year 2). Funding is currently being sought from fundraising bodies for this trial, to date without success.

The continuation of the project beyond the initial two years would depend upon the results of the evaluation. It is hopeful that there may be an opportunity to incorporate the defence-styled program into existing Carers' programs throughout Australia, avoiding the need to duplicate existing services in the medium to long term.

The release of the Vietnam Veterans' Family study increased our knowledge about the impact of a veteran's service on their partner and if the veteran is a parent, the impact of their war service on children and grandchildren.

Harsh parenting was one of the consequences of service highlighted in the report as having a significant effect on both children and grandchildren. Education of veterans and their partners about the potential impact of PTSD and other mental health issues on their parenting and as a result on the mental wellbeing of their children could help alert veterans to this issue.

There are many parenting programs that can assist with strategies to help parents cope with difficult circumstances and these together with other professional and peer services may help reduce the effects on children of current veterans in the future.

Families would be helped by increasing the knowledge of veterans' issues and the effects of war on them and their families among mainstream health practitioners – GPs, counsellors, social workers, psychologists, etc. This is best done through educational institutions and professional associations. While VVCS is available, children may be more likely to feel comfortable accessing mainstream health professionals or they may first present to a mainstream health professional if they haven't linked their own issues to their parent's service.

There are also an increasing number of partners who have met their veteran partner after discharge.

These partners have little knowledge of the relationship between service and mental ill-health and education surrounding this would be valuable to help them better support their partner.

G. The growing number of returned service personnel experiencing homelessness due to mental ill-health, PTSD and other issues related to their service

We do not know the actual numbers of homeless veterans nor do we know why veterans are homeless or at risk of homelessness.

Currently being stated as 3,000 homeless veterans although this is a guesstimate based on the 2009 'Veterans at Risk' research project, ie not based on actual data. There is no further break down as to numbers of primary, secondary or tertiary homelessness – ie primary being on the street/sleeping

rough, while secondary and tertiary are the at risk of homelessness group. To really be able to address this issue:

- We need actual data on the numbers. For example:
  - survey/consultation with ESOs about numbers they are seeing/supporting
  - homeless organisations: request these organisations ask the question about ADF service
  - Question on ADF "service" is to be included in the 2016 census. This question would provide so much information - not just about the numbers of ex-service members in Australia, but also their locations, their income levels, if they have secure/insecure housing (will also capture those couch surfing, those living in caravan parks, etc)
- The data also needs to include those who have problems with paying rent due to high private rental market costs – these persons are often at high risk of eviction or have the need to find affordable housing quickly
- Public housing issues also need to be considered, ie in each State, veterans are on same waiting list with tens of thousands of the general public – veterans do not take priority.
- While collecting the data on numbers, we also need to try to determine why veterans are homeless, eg is it due to domestic violence, ill-mental health, etc. There are a great many assumptions in the ex-service community that homelessness is due to ill-mental health, however it may be otherwise. Homelessness is not specifically about mental health, we have seen:
  - financial pressures resulting from physical ailments (of the ex-service person or a family member) which have put families at risk of homelessness
  - the urgent need for financial counselling, purely due to ill management of money
  - It should also be noted that not all relationship breakdowns are due to ill-mental health.

For us to truly address the issue of veteran homelessness we have to be able to accurately identify the problem – this requires real data not guesstimates or generalisations. The Committee's attention is again drawn to the RSL LifeCare's Home for Heroes submission for more detailed information, recommendations and case studies.

H. The effectiveness of the Memorandum of Understanding between the ADF and DVA for the Cooperative Delivery of Care

The Memorandum of Understanding (MOU) was signed 5 February 2013 and updated in November 2013 to remove reference to Veterans. The problems throughout with regard to implementation are multiple and several will be covered here.

In the introduction the MOU commences "following an injury or illness". This deliberately suggests nothing can or will be done until a specific diagnosis has been made. In fact every ailment produces signs and symptoms long before becoming definitively diagnosed and it should be prevention, where possible, and early intervention with the necessary care we are pursuing first and foremost in this relatively closed military environment. A preventive mode should be our main objective not post-illness development care, particularly when we know most DVA claims occur after transition hence the need for good medical documentation at the time of an individual's service. This is not occurring as seen by the thirty doctors who've departed the ADF this year complaining about the e-health system. As just one example with the rise of 'blast injuries' and the long-term effects this can cause, prevention efforts must be noticeably increased; Questions asked and answers documented at the

time of injury. Mild traumatic brain injury remains a poorly documented injury especially when accompanied with something more medically acute at the time of the primary care.

With regard to specific sections in the MOU:

[7] Operating Principles
These are not being adhered to as written.

[7.2] Claims: monitor, evaluate and refine the key information flows to ensure that they continue to help reduce the burden of the members and the time taken to make adjustments.
Too many people are still being discharged from the ADF on medical grounds and the liability by DVA has not been determined at the time of discharge.

The DVA On Base Advisory Service (OBAS) might be supplying information to clients and needed paperwork but they are failing to point out that everyone should have an experienced pension officer to assist with any DVA application to reduce the chances of a claim failing.

[8] The Governance
These requirements state 'assess the effectiveness of the Support Continuum using agreed metrics and use feedback from current and former ADF members'. There has been no published evidence of this occurring.

[9] Collegiate Approach
Co-operation in real terms between Defence and the ex-service community has been limited in the extreme with the two possible exceptions of commemoration and some rehabilitation sporting activity.

[10] Provision of Services
These are described in the schedules we are told. There are no schedules for the ESO members to view so these services remain a mystery. So it goes on with regards to staffing, accommodation, performance monitoring all done according to schedules. We, the ex-service community, are unable to view them despite specific requests to DVA and Defence.

[24] Communication Management
This remains cosmetic for those stakeholders not in one or other of the government departments of the MOU agreement. All the recognised contributors to ADF and ex-service personnel care should be able to contact a known public relations source and find out whatever information they are seeking or be directed accordingly. This could be a centralised Canberra directorate and does not require duplication. The service newspapers, *Defence Family Matters* (published by Defence) and *Vetaffairs Newsheet* (published by DVA) are too hit and miss in this regard. One may or may not find the particular information you seek.

The MOU needs more rigour in relation to transition; it needs a better system of ensuring that the individual is not discharged from the ADF prior to their entitlements being satisfied:

- Those persons being medically discharged should not leave the ADF until they receive a letter providing confirmation of class disability (A, B or C) from ComSuper
- Discharge should be put in abeyance until this is sorted out
- Would mean ADF salary ends one week and new entitlement begins the next week
- Would result in ex-service persons not needing to apply for Centrelink benefits
- Would stop the overpayment that often results in tax debts

The ADF/DVA MOU is a very prosaic attempt to outline how two Federal Government Departments should attempt to co-exist when both are hamstrung by a third organisation, the Department of Finance. They have failed to provide an executive summary to genuinely outline what the practical benefits of the memorandum can be to a service or ex-service individual. The depersonalising of the information provided is a disappointment for both those entrusted with its execution and those who might be potential beneficiaries. Thus the dehumanised memorandum outlined leaves many of us bereft of interest or a desire to participate.

I. The effectiveness of training and education offerings to returned service personnel upon their discharge from the ADF

The RSL is of the strong view that training and education of members should commence during their time within the ADF well before any discharge date is even contemplated. The training and education should not be left until the time of discharge as this term of reference implies.

Dr Andrew Khoo expressed this fact very well in his Joint Standing Committee on Foreign Affairs, Defence and Trade submission into the *Care of ADF Personnel Wounded and Injured on Operation* in 2013. Dr Khoo has a large Veteran consultant psychiatric practice in the Brisbane metropolitan area and he offers the following insight:

> "Contemporary academic opinion currently would favour the use of Psychological First Aid (PFA) rather than debriefing and, with respect to the military, particularly aspects of psychoeducation, information on the various symptoms to monitor for and basic coping strategies, and appropriate avenues of referral both within the ADF and externally. The Royal Marines have been employing Trauma Risk Management (TRiM) since the early 2000's. TRiM is defined as a proactive, post traumatic peer group delivered management strategy that aims to keep employees functioning, provides education and support, and identifies those requiring specialist supports. Military non-medical personnel are trained as TRiM practitioners and embedded within all units. This model has good anecdotal evidence and some preliminary scientific support. It is now also employed in the Royal Navy, the British Army and the RAF."

Many would advocate for an extension of the ADF's *Keep Your Mates Safe* initiative where junior Non-commissioned Officers (NCO) are trained to identify predictors of suicide in their men. This model could be broadened to include indicators of psychological distress, non-suicidal depression and PTSD.

Contemporary expert opinion would argue that all returning troops be provided with a PFA session – including psychoeducation on human responses to trauma, basic signs and symptoms to look for, support services, non-judgemental management and access to specialist treatment.

With ten years' experience treating current and ex-serving personnel, Dr Khoo is convinced that an ongoing, predominantly internal (i.e. on base ADF management) approach to treatment will remain a significant barrier to early identification of psychiatric illness. It is a recognised phenomenon, and a recurring theme from his therapeutic contact, that there still remains a stigma around mental illness in the male dominated military culture. Further there is a pervasive suspicion that military health personnel are not bound by the same confidentiality constraints as their civilian counterparts. Given a relative lack of civilian qualifications, many servicemen/women (with mortgages and young families) fear the impact that disclosing psychological injury will have on their ongoing employability, deployability, promotional opportunities and therefore their incomes.

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

When an individual is to be discharged from the ADF, care should be taken to involve the ADF member as much as is reasonably possible in decision making. The process of resolving the loss of one's career path is easier for an individual if they feel that it was their considered choice, or at least that their difficulties were acknowledged. The use of independent external psychiatrists/psychologists (with experience in dealing with military personnel) would reduce the perception of being deliberately moved on by the system, or of confidentiality breaches within the ADF.

Many professionals feel that this collaborative process of medical discharge along with the aforementioned defined period of rehabilitation and vocational training would allay the feelings of abandonment by the services often reported in recently discharged personnel.

This perception of rejection contributes in a significant way to anger and guilt, both of which are poor prognostic factors in PTSD, anxiety disorders, mood disorders and substance use.

During transition from ADF managed health care and support to DVA's managed health care support the process of recognition by the DVA of an individual's psychiatric diagnosis/es is for many ex-servicemen/women a gruelling, prolonged, invalidating and dehumanising experience. Whilst it's understood that strict processes are required to efficiently and fairly investigate large numbers of claims and that the Department has a defined budget, many veterans feel that they are viewed by DVA as trying to cheat the system until proven otherwise. The majority of veterans and advocates (with whom the RSL and other ESOs have contact) relate that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the Administrative Appeals Tribunal, which indicates that the DVA is looking for reasons not to provide compensation rather than ways to support their clients.

This is a difficult situation to find a suitable cost efficient solution for but the fact remains that the DVA Compensation process complicates, aggravates and perpetuates the pre-existing psychological distress suffered by veterans and their families. With 70,000 returned/returning ADF personnel from Timor and the Middle East, perhaps part of the answer is increasing the numbers of DVA delegates/case managers, reducing their caseloads, providing in-services re common veteran psychological problems, typical veteran presentations, communication styles, etc.

An individual who has been deemed medically unfit for further service in the ADF should leave the services with a defined short, medium and long term, multidisciplinary and evidence based medical discharge plan.

The inevitable exposure to traumatic situations during overseas deployment makes primary prevention of psychiatric conditions difficult if not impossible. Hence, the tenets of early identification and treatment are paramount. Basic psychoeducation, PFA and TRiM aim to improve identification of psychopathology and self-referral. It follows then that individuals identified with PTSD, anxiety disorders, depressive disorders and substance use disorders should receive evidence based best practice management whilst in the forces and, if needs be, once they are discharged. Whilst mandatory debriefing type interventions have a conflicting evidence base, the literature is consistent with regard to the benefits of early intervention once PTSD has been identified.

With regard to PTSD, meta-analysis of experimental data and International Clinical Practice Guidelines advocate for a cognitive behaviour therapy (CBT) based psychotherapeutic approach which involved trauma focused elements. This is seen as the primary therapeutic approach, which may or may not require augmentation and pharmacotherapy.

The CBT should be delivered by a trained/qualified professional and each individual should receive psychiatric review to investigate pharmacotherapeutic augmentation options. When considering management of returning troops, strong consideration should be given to group CBT for the following reasons:

- equivalent outcomes for group vs. individual treatment in PTSD
- the significant numbers of returning troops
- the relatively low numbers of specialist veterans mental health services
- service personnel's experience of receiving training in groups
- service personnel's greater comfort and support around their military peers

We would suggest that the comprehensive group programs, which are accredited by the Australian Centre for Post-traumatic Mental Health, are most applicable.

The VVCS currently funded by DVA fills a niche in supplying qualified counsellors and psychologists for individual work with veterans and their families. VVCS is often the first port of call for veterans and their families but they do not provide comprehensive group programs and are not able to appropriately address broad treatment plans given their lack of medical staff. Dr Khoo suggests VVCS would function ideally within existing health structures as a service which engages and screens individuals, provides individual counselling and group psychoeducation to those who are essentially coping or have specialist treatment options in place, and refers on those personnel with acute psychiatric symptoms for specialist assessment and treatment.

The authors of the *US Department of Defence, Guidelines for the Treatment of PTSD* feel the biggest difference that can be made to treatment outcomes is to better identify individuals with the disorder and maintain them in treatment. Experience demonstrates, these comments would be equally applicable to a service/ex-service personnel's cohort if broadened to include depressive disorders, other anxiety disorders and substance misuse. Ideally treatments should be evidence based and comprehensive, addressing biological, psychological and lifestyle elements. Where possible the use of multi-disciplinary input is optimal providing a holistic approach to the individual and family.

J. Any other related matters

It is with considerable disappointment that the earlier, excellent Inquiries held over the previous decade have failed to produce the necessary follow-up they so rightly deserved. Too few of the recommendations were adequately pursued and we now find ourselves in much the same position once more.

In June 2013 the Joint Standing Committee on Foreign Affairs, Defence and Trade Inquiry into *the Care of ADF Personnel Wounded and Injured on Operation* set out the following reasonable recommendations, amongst a number of others that were made. On close examination it can be seen that many of these excellent reforms have failed to come to pass or they have produced less than the necessary benefit that they intended to implement.

Unless or until these proposals of two years ago, concerning the best courses of action, are pursued comprehensively then this current Inquiry will deliver very little change or benefit.

When reviewing some of those earlier recommendations we see the following:

> *Recommendation 5*
> *The Committee recommends that the Department of Defence annually publish detailed written assessments of garrison health care contractor key performance indicator statistics. The Committee further recommends that the written assessments include the results of an ongoing survey of Australian Defence Force personnel regarding their experiences with the performance of garrison health care contractors.*

These may exist but they are not easily available to anyone concerned with these matters outside the Department.

> *Recommendation 6*
> *The Committee recommends that the Department of Defence address the shortcomings in Reservist post-deployment support mechanisms identified in this Inquiry as a priority.*

The RSL is not aware of a satisfactory, significant change.

> *Recommendation 7*
> *The Committee recommends that the Department of Veterans' Affairs accept complimentary therapies as legitimate treatment for psychological injuries if there is an evidence-based clinical reason to do so.*

These do not appear to exist yet.

> *Recommendation 8*
> *The Committee recommends that the Department of Defence publish periodic detailed written assessments on:*
>
> *1. The implementation of the recommendations of both the 2009 Review of Mental Health Care in the ADF and Transition through Discharge, and the 2010 ADF Mental Health Prevalence and Wellbeing Study;*

This is the example of a failure to follow through with excellent recommendations designed to improve a function from former reviews.

> *2. The Australian Defence Force mental health reform program;*

This has occurred but the implementation is patchy.

> *3. What additional enhancements have been made to current programs, as indicated in the Defence White Paper.*

Some programs have been printed along with brochures and videos eg. DVA's *High Res. App*, however we believe there's little incentive to use them.

> *Recommendation 9*

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

Some have been undertaken or commenced. However, there appears little co-ordination between their managements and the start-up times have been much too long.

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

The RSL can find no evidence that this has occurred.

Recommendation 10
The Committee recommends that the effectiveness of psychological first aid (PFA) be made a research priority by the Department of Defence, in consultation with the Department of Veterans' Affairs.

This has not occurred.

Recommendation 11
The Committee recommends that the Departments of Defence and Veterans' Affairs expedite the development of a unique service/veteran health identification number.

This has been a request for some time with no satisfactory action yet occurring.

Recommendation 13
The Committee recommends that the Departments of Defence and Veterans' Affairs coordinate to clarify the Australian Defence Force/Veteran service delivery models to reduce the complexity, overlaps and gaps in service identified in this report.
The Committee further recommends that it be provided with a progress report within six months and a final implementation report within 12 months.

We await progress reports.

Recommendation 14
The Committee recommends that a wounded or injured soldier who wishes to remain in the Defence environment and applies for a position within the Australian Public Service, for which they have the required skills and competencies, be selected preferentially. The Committee further recommends that the Government encourage private sector providers to take a similar approach to the preferential employment of wounded and injured soldiers.

It is understood this is occurring.

Recommendation 15
The Committee recommends that the Departments of Defence and Veterans' Affairs expedite the rectification of information technology connectivity issues. The Committee further

recommends that it be provided with a progress report within six months and a final implementation report within 12 months.

This still remains to be implemented to best effect and has contributed to the problem whereby a number of ADF Medical Officers have resigned this year as a result of the new E-Health introduction.

Recommendation 16
The Committee recommends that:
1. As an immediate priority, the National Healthcare community include a military/ex-military checkbox as a standard feature on all medical forms;

This has become a state based exercise rather defeating the original concept. However, this is possible with a service based identification number for life.

2. The Government commission a longitudinal tracking system to identify the engagement of military/ex-military personnel with the healthcare system.

This is currently being implemented with a two-year post discharge GP medical. However, it remains an opt-in exercise, with an op-out still being contemplated.

RSL SUBMISSION RECOMMENDATIONS

- Defence and DVA should develop an integrated, coordinated, and comprehensive PTSD management strategy that plans for the growing burden of PTSD for service members, veterans, and their families, including female veterans and Reserve members.

- Defence and DVA leaders must regularly communicate a clear mandate through their chain of command that PTSD management, using best practices, has high priority at every level. An occasional mention is not proving sufficiently effective at lower ranks.

- Defence and DVA should develop, coordinate, and implement a measurement-based PTSD management system that documents patients' progress over the course of treatment and long-term follow-up with standardised and validated instruments. This can be assisted by every service person possessing a DVA file number regardless of any accepted entitlements being present, eg. Similar to the US social security number.

- Defence and DVA should have available an adequate workforce of mental health care providers – both direct care and purchased care – ancillary staff, and resources to meet the growing demand for PTSD services. This includes clear training standards, referral procedures, and patient monitoring and reporting requirements for all their mental health care providers. At the present time this aspect is very poorly managed.

- Both departments should use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. Any new programs and services should be piloted and include an evaluation process to establish the evidence base on their efficacy and effectiveness.

- Defence and DVA should establish a central database or other directory for programs and services that are available to service members and veterans who have PTSD.

- Defence and DVA should increase engagement of family members in the PTSD management process for service members and veterans.

- PTSD research priorities in Defence and DVA should reflect the current and future needs of service members, veterans, and their families. Both departments should continue to develop and implement a comprehensive plan to promote a collaborative, prospective PTSD research agenda with established research groups, eg. Australian Centre for Post Traumatic Health in Melbourne if the cost remains beyond their budgets.

CONCLUSION

As Prince Henry of Wales KCVO said at the Australian Centenary of Gallipoli Service in Turkey, "While we honour their bravery we must also honour their emotional cost, their guilt, the sorrow and mental anguish of those who survive in the face of conflict." Today this remains just as relevant as it was one hundred years ago.

In order to perform that honour adequately we must pursue the aforementioned recommendations with speed, financial outlay and training of the personnel required to achieve this desired measurable outcome that we are all seeking. We need to communicate as a 'team of teams' and cease functioning in silo like isolation from one another.

It is important to share our successes and not waste time with poor practices. Once out of the armed forces, the city and country veteran members' interest should be served equally well through skype or whatever proves most effective for communication and the cost of distance travel must be borne by the government as required.

The conjoint acknowledgement of each of these two federal government departments' separate service delivery responsibilities must be done quickly. At the same time where the service transitioning period is shared the individual's interests are paramount and never those of either Department. Currently, there are too many exceptions to this important concept.

This inquiry is obliged to produce a demonstrable improvement in every Australian Defence Force member's mental health care, now and into the whole Defence Community's long-term future.

Rear Admiral Ken Doolan AO RAN (Retd)
National President
The Returned & Services League of Australia
23 June 2015

ENCLOSURE 2

Homes for Heroes
RSL LifeCare
P.O. Box 56
NARRABEEN
NSW 2101
PH: 0425 315 74
E:geoff.evans@rsllifecare.org.au

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

8 June 2015

RE: Inquiry: 'Mental health of ADF serving personnel'

Dear Sir/Madam

Homes for Heroes is a division of RSL LifeCare. Over the past fourteen months we have operated a homelessness service for veterans and their families at four locations across NSW. To date we have placed 54 veterans into permanent accommodation, in addition to a number of temporary placements. Homes for Heroes welcomes the opportunity to forward our submission to the Senate's Foreign Affairs, Defence and Trade Committee, in relation to the 'Mental health of ADF serving personnel' inquiry. As our expertise lies in homeless veterans, we have chosen to address the following terms of reference only:

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;
i) The effectiveness of training and education offerings to returned service personnel upon their discharge from the ADF.

In the following submission Homes for Heroes contends that veteran homelessness is a large and growing problem in Australia. We also contend that the government agencies tasked primarily with veteran welfare, not only refuse to acknowledge veteran homelessness as an issue, but make no effort to provide dedicated services to those they do come across.
Homes for Heroes was initiated as a direct result of the tragic consequences that befell our Vietnam Veterans. We strongly believe that today's generation of veterans and their families, are being sent down the same path. We do not have to be captive to our Vietnam veteran's history, but we must learn from it. Attention must be focused on addressing the issues faced by veterans today while the opportunity still exists to intervene early.

Geoffrey Evans
Director
Homes for Heroes

Contents:

1.0 Introduction RSL LifeCare

RSL LifeCare commenced in 1911 at Bare Island in Botany Bay to provide accommodation, care and support to veterans of the Crimean, Boer and Sudan campaigns. With the advent of WWI, demand for RSL LifeCare's services grew rapidly, and in 1939 RSL LifeCare relocated to Narrabeen in New South Wales. Over the years, RSL LifeCare has remained true to its vision of "Continuing in the ANZAC spirit," through the provision of residential aged care, retirement living and community care to veterans in over 20 villages throughout NSW and the ACT. RSL LifeCare is proud to extend its excellence in caring for older veterans to contemporary veterans in need of accommodation and support. Ultimately RSL LifeCare sees this as a return to its roots and hopes the help offered to these young men and women will enable them to assimilate back into society and lead rich and fulfilling lives.

It is forecast that RSL LifeCare will spend over $2 million of its own funds over the next three years to provide accommodation, support and reintegration services to homeless veterans. It is evident with the number of Vietnam Veterans entering RSL LifeCare residential aged care, aged only in their 60s, (noting that most people in the general population only enter a residential care home aged in their 80s or even later), that there is much work to be done in providing care and service to contemporary veterans to help avoid the sad results of the Vietnam Veteran generation.

1.1 Introduction to Homes for Heroes

RSL LifeCare established the Homes for Heroes program in March 2014, at Narrabeen in NSW. Since it's inception Homes for Heroes has expanded to four locations across NSW and accommodated over 50 veterans, ranging in age from 24 to 71. It should be noted that although Homes for Heroes has accommodated over 50 veterans, we do not yet 'reach out' to the veteran community and have only just begun to publicise the existence of the program.

The Homes for Heroes program is available to veterans of any conflict, ex-serviceman and woman and the families of those cohorts; provided they are genuinely homeless. In addition to long term housing, Homes for Heroes periodically provides accommodation to families and veterans on a short stay basis, such as when a mother with children is fleeing domestic violence. It is worth noting that one hundred percent of our residents suffer from mental illness. Substance abuse and addiction issues are prevalent, most are also wounded or injured, and most arrive with no possessions at all.

The program is a comprehensive rehabilitation service. We have taken the 'housing first' approach advocated by all major homelessness service providers in Australia and woven through many programs and services. For instance, every resident is required to give back to the program by doing some sort of volunteer work (unless they are actively engaged in rehabilitation). We provide exercise physiology, yoga and group and individual counselling. We also run a sailing program, community college course placements, and employment services. Homes for Heroes has a strong relationship with St John of God Hospital, a leading provider of PTSD and Drug and Alcohol treatments. It is envisaged that the majority of our residents will eventually reintegrate back into society, in some cases, they may not. Regardless of this outcome Homes for Heroes remains committed to its core principals of providing security, stability, support and opportunity to Australia's homeless veterans.

2.0 Definitions.

Homes for Heroes adopts deliberately broad definitions of the terms 'veteran' and 'homeless'. This is done to enable easy access to services without undue argument over eligibility. This may, however, place Homes for Heroes at odds with the Department of Veterans' Affairs. For instance, a veteran may own a home but be unable to return there due to domestic violence. If the veteran is subsequently living in a car, the DVA would not consider them homeless[1], but Homes for Heroes would.

2.1 Definition of the term Homeless:

Homes for Heroes currently uses the Australian Bureau of Statistics (ABS) definition of homelessness.

The ABS statistical definition states that when a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations.

The ABS definition of homelessness is informed by an understanding of homelessness as 'home'lessness, not 'roof'lessness. It emphasises the core elements of 'home'. These elements may include: a sense of security, stability, privacy, safety, and the ability to control living space. Homelessness is therefore a lack of one or more of the elements that represent a 'home'[2].

2.2 Definition of the term Veteran:

For the purpose of this submission the term Veteran includes people who:

a) Have served as a member of the Australian Defence Force, *whether they have served in a theatre of war or not*. This includes peacekeepers and reservists.

For the purposes of admission into its program, Homes for Heroes adopts a broader definition of the term veteran to include partners, carers and dependant family. These people are not included as 'veterans' within this submission unless explicitly stated.

3.0 Addressing the Terms of Reference:

3.1 The following addresses part (g) of the terms of reference, 'The growing number of returned service personnel experiencing homelessness due to mental ill-health, PTSD and other issues related to their service'**:**

The debate with the DVA around homeless veterans is centered on 'how many' veterans are homeless. The DVA uses an apparent lack of data on the numbers to justify not taking definitive action to end veteran homelessness, regardless of 'how many'. Already this year the DVA has cut its own estimates of at least 3000 homeless veterans in 2009, to 300 in 2015.

[1] Personal communication with DVA staff, May 2015. Based on a real life example.
[2] Homelessness Australia Website: http://www.homelessnessaustralia.org.au/index.php/about-homelessness/what-is-homelessness.

Below is an outline of some of the available evidence concerning the number of homeless veterans in Australia.

- The DVA commissioned an extensive research program and report into veteran homelessness in 1998, with a follow up report in 2008. Both reports were consistent in their estimate of the number of homeless veterans. The 2009 report titled Veterans at Risk stated "there are estimated to be at least 3,000 members of the veteran community in Australia who are homeless," the report also emphasises that **3,000 is a conservative estimate**.[3] Whilst the report noted a "significant group comprising younger veterans"[4] these were largely limited to peacekeeping operations such as East Timor. The full impact from conflicts such as Iraq and Afghanistan is only just beginning to be felt now and is not likely to peak for some time. Mr John Thompson, who was involved in the production of both reports stated that there had been little response by the DVA to either report, and that the 2008 report was not made public.[5]
- In their work in the Street to Home program since 2010, HomeGround Services has consistently found that approximately 8% of people who sleep rough in the inner city of Melbourne are veterans. At the last City of Melbourne Street Count held in 2014, 142 rough sleepers were identified. In an internal survey conducted during May 2015, HomeGround Services and Hanover Welfare Services had 16 people seeking assistance who were veterans, including a woman and her teenage daughter living in their car.
- Homelessness NSW, the NSW peak body for homeless service providers in NSW, estimates that 12 percent of the 2,000 rough sleepers across Sydney are veterans. Acting CEO Digby Hughes estimated that total numbers of homeless veterans in NSW is likely to be around 8 percent of a total of 28,000.[6] Interestingly the 2008 Veterans at Risk report stated that mainstream homeless service providers were consistently likely to underestimate the number of veterans accessing their services because no attempt was made to identify a client's veteran status. When a number of high volume agencies were asked to identify clients accessing their services over a two week period, the data collection indicated that 8 percent were in fact veterans.[7]
- Homes for Heroes has accommodated 54 veterans in the last 14 months. While this number does not sound high it must be remembered that Homes for Heroes does not actively seek out homeless veterans, and further, deliberately stagnated its growth to allow for careful expansion. Given the current take up rate we anticipate a very high demand for our services into the future, particularly as veterans entering the program are increasingly younger veterans of Iraq and Afghanistan.[8]

[3] Veterans at Risk, Department of Veterans' Affairs, 2009, viii.
[4] Veterans at Risk, Department of Veterans' Affairs, 2009, p.viii.
[5] Australian Alliance to End Homelessness, Veterans and Homelessness, 5th March 2015, Meeting Minutes, p.1.
[6] Personal communication with Digby Hughes at Homelessness NSW offices, 19 December 2014.
[7] Veterans at Risk, Department of Veterans' Affairs, 2009, p. 36.
[8] 41 of 54 veterans entering the program served post-Vietnam, of these over half have served in Iraq or Afghanistan.

- Comparable countries such as the US and UK estimate that 11 percent and 6 percent respectively, of their homeless adult populations are veterans. [9]
- As a result of recent media attention the DVA recently revised its assessment of the number of homeless veterans in Australia down to between 200 and 300 nationally.[10] The following outlines the methodology used to determine their current estimate.

3.2 Methodology used by the DVA to determine their current estimate of 300 homeless veterans nationally:

- *"In late 2011/early 2012, DVA conducted data matching of DVA clients who were also clients of the Department of Human Services and who had a homeless tag. DVA also had an exhaustive look at every DVA client who had moved more than twice in the previous year. This identified 12 clients where further investigation was carried out and identified 2 clients who were in need, and subsequently received, immediate housing support.*

- *In 2014 and 2015, further analysis occurred that included consideration of homelessness characteristics from the most recent Australian Institute of Health and Welfare report, Specialist Homelessness Services 2013-14. This report noted the following characteristics of the 254,000 users of homelessness services in the 2013-14 financial year:*

- *59 per cent female, 41 per cent male;*
- *19 per cent aged 25–34 years (largest group); and*
- *under 3 per cent over 65 years (smallest group).*

  Not all those reported as homeless were sleeping rough:

- *8.2 per cent were categorised as living rough (no shelter or improvised/inadequate dwelling);*
- *55.2 per cent were described as 'at risk' of homelessness; and*
- *13.1 per cent were in short term or temporary accommodation.*

  Comparing the characteristics of homelessness with a snapshot of DVA clients, in late 2014 showed that just over 67 per cent of DVA clients are 65 years of age or older and 80 per cent are 55 years of age or older. Women, predominantly the widows of World War II veterans, make up 41 per cent of those aged over 65 years of age, but only make up 18 per cent of those under 65 years of age. DVA has only a handful of clients aged under 18. This comparison shows that the characteristics of DVA clients and users of homelessness services are significantly different and that the majority of DVA clients are in the group that is least at risk of homelessness.

- *DVA also continues to review data in respect to our client admissions to hospitals. All hospitals in each state and territory are required to provide data on hospital admissions that is then provided to the Commonwealth. This data includes information on homelessness and inadequate housing.*

- *The 2013 data shows that approximately 85,000 (about 1 in 3) of DVA Treatment Card holders had one or more hospital admissions during the year and of these, 12 were reported as homeless and 28 as having inadequate housing. The average for the five years from 2009 to 2013 was 16.5 homeless and 24 with inadequate housing.*

- *Extrapolating from the admissions data, and using 330,000 as the total DVA client number, would indicate that approximately 65 DVA clients may be homeless and 109 in inadequate housing. When taking into account 'potential' DVA clients, i.e. ex-Australian Defence Force*

---

[9] 'What puts veterans at risk of homelessness', Epidemiologic reviews, http://blog.oup.com/2015/05/veteran-homelessness-risk-factors/ p.2. & 'UK Veterans and Homelessness', Executive Summary, British Legion, 2008, p.1. http://www.britishlegion.org.uk/media/31582/LitRev_UKVetsHomelessness.pdf

[10] Deputy Commissioners Consultative Forum, Tasmania, 30th October 2014. http://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/tascf/tas30oct13.pdf

service men and women who are not currently DVA clients, this would match what DVA estimates the homeless and, at risk of homelessness, figure as being; roughly between 200 to 300. However, DVA has no formal mechanism at this point to validate this estimate".[11]

3.3 Analysis of the methodology used by the DVA to determine their current estimate of 300 homeless veterans nationally:
(The following is the opinion of mathematician DR Richard Stone, who was asked to examine the methodology the DVA used to determine its current estimate of 300 homeless veterans nationally.[12]

The estimate of approximately 3,000 homeless vets in the full report [Veterans at Risk, 2009] seems very reasonable, likely in fact an underestimate although there really is insufficient info to be confident about that. The DVA estimate of only 300 does seem absurdly low. Here is a brief summary of the calculations and why I believe this:
The first-draft in the full report estimate is approx 5,000 homeless vets [unadjusted for age]. This is a very simple calc as follows:

- *based on census info, 4.9% of the population is a vet or related to/dependent of a vet etc (965,100 out of approx 20-21m people)*
- *on census night there were 104,000 people experiencing homelessness*
- *if the percentage of homeless veterans exactly matches that of the population as a whole, then there would be 4.9% x 104,000 homeless vets, i.e. approx 5,000*

The DVA says this must be an overestimate because homelessness is much more prevalent among young people whereas the vet population is skewed heavily towards older people.

This is true, but the full report adjusts for this carefully in coming up with its final estimate of 3,000 by breaking the 104,000 homeless population into age-groupings and applying appropriate percentages to each according to how much of each cohort is made up of veterans in the population as a whole.

As such the 3,000 estimate seems a very reasonable default assumption. There are in fact some good reasons for expecting it to be an underestimate, e.g.

- *International research (e.g. in USA) suggests veterans are likely to be over-represented among the homeless, not just represented at exactly the same rate*
- *The census likely underestimates the number of homeless as a whole (i.e. the 104,000), and in particular is just a snapshot whereas many people will move into and out of homelessness, perhaps multiple times during a year as they exhaust options with staying with friends etc. More to the point, the DVA estimate of only 300 seems absurdly low:*
- *It would suggest that vet homelessness occurs not only at a lower rate than the general population, but in fact at only about 6% of the rate in the general population – this hardly seems credible given the extra stresses (PTSD, adjustment to civilian life, family separation and breakdown, etc) that are known to be present among the vet population*
- *The full report details multiple lines of evidence from surveys with assistance organisations etc demonstrating that these organisations materially underestimate what proportion of their clientele are vets and demonstrating that vets frequently do not self-disclose their vet status or use their DVA card etc when applying for services. As such the reliance by DVA both on self-disclosure of homelessness by vets and on this info being obtained and passed on by hospitals is bound to lead to a massive underestimate*

[11] Email from Luke Brown, Department of Veterans' Affairs, 5 June 2015.
[12] Witheld but available on request.

- *Most significantly, if 150-300 really were a realistic estimate, it beggars belief that you would be already aware of 54 cases from what is a very narrow selection pool*

- *It seems to me that if you have Census data you go with that rather than the self-reporting data from hospitals. It would be interesting to see how the hospital estimate (for the population at large) would compare with the correct Census estimate (for the population at large).*

  Overall, it's obviously very hard to get a clear handle on the exact numbers of homeless vets, but we believe you are right to regard the DVA estimate as absurd and we view their reliance on self-reporting of homeless status by vets to hospitals in the course of unrelated activity as being obviously inferior as a means of estimating this number compared to the approach used in coming up with the 3,000 estimate. 300 is also implausible when you consider the fact that it would suggest vet homelessness occurs only at about 6% of the rate within the population as a whole when in fact it is likely to be more prevalent for well-known reasons.

It is clear that there is a significant discrepancy between the DVA's 2008 and recent estimates of Australia's homeless veteran population. The 2008 estimate of 3000 is considered far more likely than 300 by those providing front line services to homeless veterans. One homeless veteran reasoned: "the DVA won't act because it is looking for a forest and ignoring the trees; if they just started collecting the trees they would soon have a forest".

Recommendations:

- The DVA adopt a zero tolerance approach to veteran homelessness.
- The DVA accept that the number of veterans experiencing homelessness is likely to be higher than its recent estimate of 200-300, and that regardless of the number; the DVA adopt a veteran centric approach to advocate for, and assist veterans who are homeless.
- The DVA issue a response to its 2008 report 'Veterans at Risk', taking particular note of the options and recommendations contained within the report.
- That any future plan to address veteran homelessness include the partners of veterans, particularly when they are forced to separate as a result of the veteran's condition.

4.0 Causes of veteran homelessness.

The experience of Homes for Heroes is consistent with the findings of the Veterans at Risk report (1998 and 2008), and the findings of extensive research conducted in the US.[13] The greatest predicators of veteran homelessness are:

- Mental illness;
- Substance abuse (alcohol, prescription and illicit drugs);
- Family breakdown (often as a result of the previous two); and
- Financial problems.

4.1 Mental illness and Substance Abuse.

The following draws on the experience of Homes for Heroes, it is clearly consistent with recent findings by US based organisations offering similar services. Our experience is as follows:

[13] 'Veterans at Risk', Department of Veterans' Affairs, 2009, p. 23 & 'What puts veterans at risk of homelessness?' Epidemiologic Reviews, http://blog.oup/com/2015/05/veteran-homelessness-risk-factors/, p.2.

- All of the fifty-four veterans that have entered the Homes for Heroes program suffer from ongoing complex mental illness.
- By the time veterans become homeless they are too unwell to access support services, such as psychiatric help (consider for instance that severe depression is equated with paraplegia)[14]. While DVA will fund access to mental health services **homeless veterans require comprehensive case management services to assist them to access help**. In most cases homeless veterans require whole of person rehabilitation, including assistance with issues such as family and criminal law, debt, dependants, pain, substance abuse and a range of treating specialists, etc. The US considers it necessary to allocate a permanent case manager to any veteran identified as homeless.[15]
- In most cases veterans entering the Homes for Heroes program, have poor mental and physical health, these conditions were exacerbated by a difficulty in achieving continuity of health care. Veteran transience, and in many cases General Practitioner transience, highlight the need for DVA case managers.
- Veterans experiencing severe mental illness are often hospitalised in private clinics for treatment. **No homelessness risk assessment is conducted upon discharge, and veterans are being discharged into homelessness**. Homes for Heroes has developed a strong relationship with St John of God psychiatric hospital in Richmond in NSW. To date we have accepted 15 veterans into Homes for Heroes straight from this hospital. The lack of homelessness screening is not limited to private clinics. Other institutions, such as public hospitals, prisons, etc, do not screen for homelessness. Sadly, they also make no effort to identify a client as a veteran. If these institutions did identify these patients and prisoners as veterans then assistance should and could be provided to best ensure they are supported upon their return to the community.
- A high proportion of veterans entering Homes for Heroes have drug and alcohol dependencies, with most having been hospitalised for treatment. Lack of follow up support after discharge leads to relapse and re-hospitalisation. One of our veterans has been through this process 18 times.

4.2 Family Breakdown.

The following addresses part F of the terms of reference: 'The support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD'.
Homes for Heroes has observed that family breakdown is a significant cause of homelessness. The following are extracts of an account written by the wife of a veteran who entered the Homes for Heroes program in February 2015. We believe her account encapsulates the experience of many families and carers of contemporary veterans who suffer from mental illness:

[14] The Impact of Mental Illness on Society, http://www.coedu.usf.edu/zalaquett/gua/TheImpactofMentalIllnessonSociety.htm, p.1
[15] National Coalition for Homeless Veterans 'DVA Homeless Veterans Assistance Programs', www.nchv.org/index.php/policy/updates/legislateive_update/ p.36

4.3 Partner of a Homeless Veteran: Case Study.

"I was never made aware of the difficulties my partner would face upon return to his family or any signs of mental illness that I could look out for. I was not educated on how to deal with such a transition or how I could find support for him if needed. I, in fact, had never even heard of Post-Traumatic Stress Disorder.

When he returned from overseas, we quickly became established and reunited with family and friends. I started to notice changes in his behaviour. He seemed easily agitated and on occasions he became violent. He chain smoked, and began to drink to excess. He also began using recreational drugs as well as medications prescribed for his moods. After a while he withdrew socially and he seemed disconnected from us.

At this time I still had no contacts or supports within the defence community to reach out to for support with these unusual behaviours he was exhibiting. After days on end of my partner returning home from work intoxicated, I turned to his commanding officer who placed him into involuntary hospitalised care for his alcohol abuse for two weeks. He was then deployed overseas again and I remained in situ with the children. I established my own business which I ran from home around the children's needs, and our home life became more stable.

When he returned from this, his second, overseas deployment we purchased our own home and we subsequently moved again. We were still in the same neighbourhood so I expected that the children's and my lifestyle would remain the same, albeit with positive changes to include "Daddy". After some time, he discharged from the Army and gained a good civilian job. Yet despite his excellent management skills he struggled with the transition to civilian life. He developed severe night sweats, restless legs, shaking, and night terrors. He became more aggressive and increasingly violent and his adverse behaviours escalated. He was detached from the children and myself, spending more and more time drinking, gambling, and mixing prescribed medications with illicit drug use.

He frequently came home from work stating that he was having altercations with other staff members and we were both worried that he would have violent episodes at work. He eventually resigned from his job. Our life was in turmoil and I was struggling to provide for the family and maintain stability at home. His lifestyle had become so out of control that he stole money to support it and was lying to me about it. He had numerous affairs and would often disappear for days on end. He was also experiencing blackouts and flashbacks.

The children and I became increasingly subjected to episodes of severe domestic violence. I believed my life to be in immediate danger on numerous occasions. The children and I were often terrified and I would need to remove us for safety. This was now happening on at least a weekly basis. On one occasion he completely destroyed our family car. He slashed the seats and tyres, ruined the dashboard, jumped up and down on the bonnet and the roof, and kicked in every side panel. The following morning he reported the destruction to the police, having no recollection of his involvement in the matter. On two separate occasions my partner attempted suicide. On both occasions I called the ambulance against his demands and as a result I suffered physical injuries from his violence. I tried to remain supportive and encouraging despite, at times, living in fear for my life.

It was at this time I began the arduous task of searching for the help we so desperately needed from doctors, counsellors, DVA, VVCS and the internet. It seemed almost impossible for me to access assistance via DVA as we were not legally married. I was treated only as a number and it became a full time job for me to complete paperwork and then follow up. After multiple doctors visits, VVCS approved psychology sessions, two psychiatric hospital admissions, numerous medical assessments and claims, my partner was finally provided with a DVA approved psychiatrist and subsequently diagnosed with severe combat related PTSD, Depressive Disorder, Anxiety and Alcohol abuse. He was hospitalised for PTSD on four occasions within the next twelve months and afterwards he suffered with extreme remorse and guilt. Upon discharge he

would be desperate to regain control over his life and the impact on the children and I. He would often say that he couldn't see how he could regain control because all he could see was fear in our eyes.

In my desperation to keep my partner alive and safe I began contacting partners of PTSD sufferers in America for guidance on dealing with PTSD. Neither DVA nor VVCS provided any assistance on how to handle a veteran struggling to transition to civilian life, or any guidance on living with PTSD. We were offered family counselling through VVCS. We had only attended one session before he received his DVA payout, purchased a high powered motor bike which he subsequently wrote off with one of his mistresses on board during a high speed police chase, high on drugs and alcohol and decided the session was not helpful and he would no longer be attending.

We went on a Christmas holiday with my parents and my brother, during which time he abandoned us and returned to Sydney, leaving the children and I stranded in Queensland. He said that he was going to admit himself back into hospital for treatment. I phoned the hospital but they would give me no information whatsoever. I couldn't even confirm if he had been admitted or not. I phoned DVA, VVCS, his doctors, and counsellor but no one would release any information due to privacy laws. When the children and I arrived home I saw that he had removed his belongings. I had not heard from him in three weeks and was extremely worried about him. He finally contacted me and advised he had been discharged from hospital, however it soon became apparent to me that he had lost all sense of reality. He subsequently discontinued seeing his psychologist and psychiatrist. I did not know where he was living and had no answers for the children when they asked. He started a new relationship with a young woman and he took her on an expensive, luxury overseas holiday. He did not admit that he had begun the relationship to me and insisted they were only friends.

I continued to seek help for him and to manage the children. I was under severe financial pressure and needed to manage my business effectively in order to maintain our lifestyle. DVA did arrange a nanny service to help me continue working extended hours, however the service was unreliable and my business suffered and eventually folded. The strain of our situation also began to negatively impact on our children's behaviours: Our eldest son started to rebel at school, fighting and displaying aggressive behaviours. He did not hand in work, and began to receive much lower marks than usual on his tests. He was suspended from school and was also arrested and charged by police for applying graffiti to public property. Our daughter withdrew from socialising with friends and had increasing bouts of depression and anxiety. She was bullied at school and then started to self-harm and state she was suicidal. She now sees a psychiatrist weekly to help with her issues. Our youngest son however reacted quite differently. He became more relaxed and happier. He had never formed a strong bond with his father and was pleased that he had gone.

I was not coping with the breakdown of my 18 year relationship and eventually suffered a nervous breakdown. I was admitted to hospital after being found unresponsive and in a catatonic state. The children were placed in temporary care with a relative. I did the best I could to recover and regain custody of the children. I was prescribed strong medications to help me cope and help me sleep. However, at times I felt suicidal and was diagnosed with vicarious PTSD, major depressive disorder and severe anxiety with panic attacks.

VVCS were made aware of my hospital admission and my mental health. They offered me six sessions with a psychologist. Unfortunately the only psychologist in my local area had previously treated my partner so, as it was a conflict of interest, was unable to treat me. Regaining custody of our children was conditional on me receiving ongoing, regular, professional treatment, which I commenced at great expense when I was already struggling financially.

I have now regained custody of our children although I did not receive any further assistance from DVA or VVCS. I rely heavily on my parents and my brother for financial, emotional, and practical support. Although in doing so, I feel that I am increasingly a burden and inconvenience

to them. I am unable to financially maintain my own treatment as well as the cost of the medications I need. I struggle every day to keep food on the table; put a roof over mine and my children's heads and to pay bills. I have postponed surgical procedures for my daughter and myself because I cannot afford them. My sons have been placed on priority wait lists for counselling through the public system. Twelve months on and they are still a "priority" but have not yet received any counselling.

DVA acknowledges the impact of veteran's experiences on their families, including mental health issues for family members. They publicise that they offer treatment and support programmes aimed at providing care for veterans in a family sensitive way, however the programmes are based on the family members providing support for the veteran, there is no programme providing support for the family members. And, in all of my correspondence with DVA I was offered no information on said programmes. The children and I are doing the best we can, taking one day at a time. I cannot think what the future holds for us".[16]

In the above case study the veteran eventually chose to leave the household. He subsequently lived in his car for five months before he was referred to Homes for Heroes by a friend. In other cases however, it is the family that is forced to flee, yet there are no services dedicated to helping veteran's families should they be become homeless.

Recommendations:

- The DVA expand the definition of 'homeless veteran' for the purpose of benefits eligibility to include a partner or carer fleeing domestic violence, or other dangerous circumstances within the home, including where the health and safety of children are at risk.
- The DVA adopt a similar program to the Supportive Services for Veteran's Families Program, instituted by the US Veterans' Affairs Department in 2008. The program provides tangible assistance for bond deposits, rent and mortgage assistance, utilities assistance, re-housing, relocation expenses and other supportive services.[17]

4.4. Financial Problems:

Veterans entering the Homes for Heroes program often have debt and financial problems they cannot resolve themselves. While this is often linked to poor mental health (for instance when a veteran suffers from a gambling addiction), systemic failures on the part of Defence, DVA and Comsuper also cause of homelessness.

The existing administration process for serving veterans transitioning out of Defence does not adequately safeguard against adverse financial hardship being suffered by impaired or incapacitated veterans and their families. Serving Defence members identified for medical discharge are issued a separation notice. Members are then encouraged to submit claims for liability to DVA as part of the 'separation process'. However, members can elect to accept the separation without submitting claims to DVA. This occurs if the member ticks the first box on the separation notice as follows:

Box 1: I elect to finalise my DVA claim(s) for liability after my separation has occurred or they have already been determined or I will not be submitting any DVA claims; or

Box 2: I request to have my separation held-in-abeyance (HIA) until my DVA liability claims are determined and will supply a copy of my DVA Lodgement Receipt, and written justification, to the

[16] Name withheld but available on request. As detailed in emailed account on 5 February 2015.
[17] National Coalition for Veterans Homelessness, http:www.nchv.org/index.php/policy/updates/legislative_update, pp.10-11.

MECRB Secretary.

Regardless of which box the veteran selects, the DVA will not make a determination on the veteran's income entitlements, before Comsuper determines the veteran's class of pension. Unfortunately, Comsuper will not commence assessment for a military pension until the veteran has discharged. DVA offers an interim gratis incapacity payment at minimum wage **for 4 weeks**. This is intended to 'bridge the gap' while Comsuper undertake their assessment. Assessments for A, B and C class pensions under Comsuper can take **up to 24 weeks**. This means that a veteran could be permanently impaired, permanently incapacitated and **without any income for over 3 months post discharge**. The following case study is an account of Captain Peter Mullaly, a veteran of Iraq who became homeless as a result of the above:

4.4 Homeless Contemporary Veteran: Case Study.

"On the 13th Aug 2014 I was medically discharged from the Australian Army after 10yrs of active service as an Officer. At this point in time I was medically unfit for work and as such had no income. These and other issues lead to a period of rough sleeping and ultimately homelessness where I had no home for over 3 months (I couch surfed and lived in a tent) until a 7 week hospital inpatient stay for treatment of PTSD and Drug and Alcohol abuse before entering the Homes for Heroes program facilitated by RSL LifeCare.

There are a number of common issues which are apparent across veterans who face homelessness/rough sleeping or who are at risk of experiencing it, these are:

- *Mental Health Issues resultant from service, namely PTSD,*
- *Physically injuries and often associated Chronic Pain,*
- *Family and Relationship Breakdown,*
- *Unemployment due to Mental Health and/or Physical Injuries,*
- *Financial issues/difficulties,*
- *Difficulties accessing DVA/MSBS entitlements, and*
- *Social isolation and Welfare difficulties.*

It was because of the above issues that I ended up homeless and suicidal.

As a my period of service fell after 01 July 2004, compensation and rehabilitation entitlements fall under the Military Rehabilitation and Compensation Act (MRCA) and pension entitlements resultant from being Medically Discharged processed through the Military Superannuation Benefits Scheme (MSBS).

A key fault of the transition process, which directly contributed to my experience of homelessness, was the process by MSBS to determine my entitlement to a pension and the associated effects and restrictions in the payment of incapacity entitlements from DVA while this occurred.

In summary the main issue is the fact that MSBS does not START processing your claim for a pension until the date your discharge takes effect. The processing of a pension claim is at a minimum of 8-12 weeks, most often longer. This is regardless of the date of your application, i.e. I had submitted all required claim forms, paperwork and supporting documentation prior to my discharge date but this does not matter, MSBS will only start to process your claim after the date your discharge takes effect. Further, if the reason you cannot work is as a result of an accepted condition which DVA accepts liability for you normally are entitled to "Incapacity Payments" which are paid at a rate of your previous income when you suffer a loss of income due to an accepted condition. However if you are in the position that MSBS is still processing you pension determination; DVA will only pay an "Interim" benefit. This benefit is less than the national minimum wage.

As a result, in situations where you are being medically discharged and unable to work due to service related conditions and even though you are entitled to incapacity payments from DVA, you are left in a position where you are in receipt of an income less than the nation minimum wage until such a time your pension entitlement is determined and due to the processing rules

this does not even commence until you are discharged and experience a loss of income and is not determined for a minimum of 2-3 months (and most often longer). As a result of this I could not afford any form of accommodation let alone other basic living costs and subsequently found myself homeless. This clearly had the follow on effect of compounding all the other issues I was facing such as dealing with such as PTSD and other mental health issues, rehabilitation and treatment of physical injuries, maintaining access to my 3yrold daughter, trying to reintegrate/transition from the military into civilian life and numerous other social and welfare issues."[18]

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

Unfortunately electing to have your discharge (from Defence) held in abeyance until these matters are finalised (Box 2), is not an automatic guarantee of financial security either. Homes for Heroes currently have two residents that were **discharged by the ADF while they were still in hospital** receiving treatment for their service related conditions. In one case Homes for Heroes was contacted by Defence to provide housing for the member after he was discharged. In the other case **the member discharged into homelessness**. An Account of her experience follows:

4.5 Iraq Veteran Discharged by the ADF into Homelessness: Case Study.

"The day I received my medical discharge I was recovering in St John of God (SJOG) hospital after police interviews into a vicious sexual assault by a Senior Sailor. I was already trying to deal with the enormity of bullying and intimidating behaviour I received from a fellow officer in a warship going to the Gulf War under Operation Slipper that left me totally incapacitated. I was made to sign the medical discharge under duress in hospital, and then, on 28 Jan 15 I received notice that I had no option but to take the medical discharge on 25 Feb 15. I was asking for only what was fair, that was to finish the out-patient program at SJOG in mid-May 2015 prior to discharge so that it did not disrupt my treatment. The hospital itself strongly discouraged anyone to leave their job, or move, or make any significant changes to their life because it impacts their treatment at the highest stress levels. I was forced 3 months into my treatment to take the medical discharge meaning that I lost everything including job, income and home.
Best treatment for me only started in August 2014 when I was placed into SJOG and had a great mental health team treating me. Prior to this I had nothing. I even paid $860 out of my own pocket to pay for a psychologist that was benefiting me because Defence Joint Health Command could not provide me the treatment I needed. They say early intervention is imperative. It took Defence 13 months before I received the treatment I needed. I initially had anxiety when I came off the ship in July 2013, then PTSD symptoms began in early 2014 when I was posted back to the same base exposing me day after day to the previous trauma, then 6 months later depression hit.
It is a hard enough battle every day to be living with mental health issues and scarred from my Service; it is even harder to battle on without support networks, without anyone who really has a clue about what happens post Defence, without an income, without a home, without fair treatment and trying to start all over again because I served my Country. Thankfully, in late

[18] Statement by Captain Peter Mullaly (retired), 5th June 2015.

March 2015 I *was one of the fortunate ones to be part of the Homes for Heroes program providing me refuge and support, without them I would be homeless today.*
I am deeply anguished by what I have seen in the Defence Force and what I have personally experienced at all levels. I am human. I am female. I am hurting. I am scarred for life. I was unfairly treated."[19]

Recommendations:

- Comsuper commence assessment for pension class and eligibility as soon as the veteran is classified J5 (pending medical discharge), in order to ensure there is a seamless financial transition from Defence Salary to financial provisions under Superannuation/DVA legislation.
- Defence remove the option for veterans to elect to separate without commencing claims through DVA, in order to safeguard veterans separating from Defence without adequate financial, medical or psychological support.
- Defence not discharge veterans whilst they are still receiving treatment, particularly if their discharge is likely to greatly impact that treatment and cause undue harm to the veteran.
- Members joining the ADF be automatically enrolled onto the DVA system in order to reduce claims processing times.
- Families of veterans be offered the same services and entitlements as veterans.
- Public and private health providers providing mental health services to veterans (particularly those contracted to the DVA), be required to conduct a homelessness risk assessment prior to discharging a veteran. Such a standard screening tool has been developed in the US and is contained below. It is imperative that such a tool be centrally recorded by the DVA and a plan to provide assistance to those that screen positive for homelessness be implemented.

4.6 U.S. DVA Homelessness Screening Tool.

U.S. Department of Veterans Affairs
Homelessness Screening Clinical Reminder

Screen not performed:
q Already receiving homelessness services or assistance
q Long-term resident of Nursing Home/Long-Term Care Facility
q Declines screening at this time
q Veteran/Caregiver unable to answer

1. In the past 2 months, have you been living in stable housing that you own, rent, or stay in as part of a household?
q Yes, living in stable housing à Proceed to question 2
q No, not living in stable housing à Proceed to question 3

2. Are you worried or concerned that in the next 2 months you may NOT have stable housing that you own, rent, or stay in as part of a household?
q Yes, worried about housing in the near future à Proceed to question 3
q No, not worried about housing in the near future à Reminder completed

[19] Name withheld but available on request, 11 June 2015.

3. Where have you lived for MOST of the past 2 months?
q Apartment/House/Room – no government subsidy
q Apartment/House/Room – with government subsidy
q With Friend/Family
q Motel/Hotel
q Hospital, Rehabilitation Center, Drug Treatment Center
q Homeless Shelter
q Anywhere outside (e.g., street, vehicle, abandoned building)
*q Other *_____*

4. Would you like to be referred to talk more about your housing situation?
q Patient agrees to referral
q Patient declines referral at this time – given information for future reference

What's the best way to reach you?
How to reach:_____

5.0 Housing Support Services Currently Available to Veterans:

The following addresses part E of the terms of reference 'The adequacy of mental health support services, including **housing support services**, provided by the Department of Veterans' Affairs (DVA)'.

There are currently no Government services that provide specific assistance to homeless veterans. The Department of Veterans' Affairs says housing services are a "State Government responsibility and DVA has no direct legislative role in the provision of housing and/or accommodation services."[20] State based homelessness service providers, however, do not recognise veterans as an 'at risk' group requiring special services.[21] This is in part because homeless service providers do not ask consumers if they have served in the Australian Defence Force,[22]and partly because the DVA does not have accurate data on the number of homeless veterans.
The following draws heavily on the experience of veterans entering the Homes for Heroes Program over the last 14 months.

- A homeless veteran contacting the DVA, who does not have a dedicated case worker from the DVA's complex case management cell, will be told to 'call Centrelink'[23] (The DVA calls this a 'referral'). It is our experience that by the time a veteran becomes homeless they are too mentally unwell to access Centrelink's services. It is also our experience that veterans will not access mainstream homelessness services for reasons of self-denial (I don't have a problem), pride, and the fact that veterans are taught to live rough and prefer to do so rather than associate with the general homeless population.
- Veterans with a dedicated case worker from the DVA's complex case management cell (Sydney office), will be assisted into accommodation at Homes for Heroes.
- The Veterans and Veterans Families Counselling Service (VVCS) operate a Crisis Assistance Program. The program is not intended to address homelessness but rather provide short-term 'time out' accommodation to veterans experiencing a family crisis. The maximum duration is 5 days.[24] The VVCS Sydney office referred to Homes for Heroes' our first client ever, and has made a number of referrals since.
- The Defence Home Ownership Assistance Scheme is an ADF retention and recruitment initiative. It is not intended to, and does not, address homelessness.

[20] DVA, cited in 'Diggers Back Home, But Homeless'. https://au.news.yahoo.com/a/25497455/diggers-back-home-but-homeless/, 13 November 2014.
[21] No effort is made by existing homelessness service providers to identify clients as veteran or otherwise. This is also the case more broadly such as in prisons, family violence, clinics, etc.
[22] Australian Alliance to End Homelessness, Veterans and Homelessness, 5th March 2015, Meeting Minutes, p.1.
[23] Personal communication with veteran from Homes for Heroes.
[24] VVCS Factsheet HSV28, Crisis Assistance Program, p.1.

It is telling that when contacted by a homeless veteran, the Australian Government's departments tasked with the care of veterans, namely: *the DVA, the VVCS and, in one instance the Department of Defence,* have no alternative but to call Homes for Heroes and seek our assistance to accommodate their homeless clients. We reiterate that the debate within Government must shift quickly from 'how many' veterans are homeless to 'ending veteran homelessness' regardless of the number.

Recommendations:

- The DVA assume a legislated responsibility for homeless veterans.
- State based homelessness service providers be required to ask their clients if they are veterans, or the family of a veteran, and this information be forwarded to the DVA.
- State based homelessness service providers recognise veterans or the family of a veteran as an 'at risk' group requiring special services.
- The DVA establish liaison positions to work with state-based homelessness service providers to advocate and care for homeless veterans.
- The VVCS Crisis Accommodation Program be enhanced and broadened to include homelessness.
- DVA review the extensive efforts and initiatives undertaken in the US to end veteran homelessness
- DVA fund a trial and concurrent evaluation of a Homes for Heroes style program.

6.0 Conclusion

Homelessness is the end result of problems that an individual cannot resolve by themselves. Veterans with serious mental illness, chronic substance abuse and other disabilities will need supportive housing over a long period of time, and in some instances for the rest of their lives. Regardless of the pathway to homelessness there are two crucial and mutually reinforcing aspects to ending it.

1) The provision of safe, secure and stable housing (Housing First);
2) Ongoing case management.

The provision of both will enable veterans to lead the most productive and fulfilling life possible given their circumstances. Sadly at present the DVA provides no housing services and limited case management to only a handful of veterans. Regardless of whether there are 300 or 3000 homeless veterans across Australia, veterans are at greater risk of becoming homeless due to poor mental health, substance abuse, family breakdown and financial problems. Tragically there are no services dedicated to helping them.

Homes for Heroes is experiencing a growing trend in homelessness among Iraq and Afghanistan veterans, as are other coalition countries such as the US and UK. We believe there is an urgent need to develop a coordinated approach to eliminate and prevent homelessness among all veterans.

Geoffrey Evans
Director
Homes for Heroes