Joint Standing Committee on Foreign Affairs, Defence and Trade

Inquiry into transition from the Australian Defence Force (ADF)

Submission by the Veterans' Advisory Council and the Veterans' Health Advisory Council

South Australia

12 July 2018

The Veterans' Advisory Council and Veterans' Health Advisory Council of South Australia welcomes the opportunity to make this submission regarding the discharge, and transition to civilian life, for those who have served in the Australian Defence Force (ADF).

South Australia, the Australian Defence Force, and Veterans

South Australia is home to various Defence units and organisations including units from the Army's 1st Brigade, the Royal Australian Navy, and the Royal Australian Air Force. It is estimated there are more than 3,000 serving personnel and their families in the Adelaide Metropolitan area alone. At the end of their military career some serving personnel will transition from the military to the South Australian community, and others will transition to an interstate location. Either way, the Government of South Australia is committed to supporting serving personnel in the broader South Australian community in all stages of their career, up to and including transition from the military and re-integration into civil society. This commitment is evidenced by the re-development and sustainment of veteran-specific mental health facilities such as the Jamie Larcombe Centre and Ex-Service Organisation Partnerships Hub. Further, South Australia is in a unique position to offer some commentary on matters impacting transition as the state is also host to a large body of defence industries, represented by the Defence Teaming Centre, which is an excellent conduit to employment that builds upon service experience.

To help facilitate coordination of the above, and linked service provision, South Australia has created two representative councils to advise ministers on issues that directly impact the health and wellbeing of veterans in South Australia. The Veterans' Advisory Council (VAC) advises the Minister for Veterans' Affairs (the Premier), and the Veterans' Health Advisory Council (VHAC) advises the Minister for Health and Wellbeing.

The VAC and VHAC

The VAC and VHAC were established in 2009. Members of both Councils include veterans and their families, veteran community leaders, current serving personnel, including unit level commanders and academics with expertise in veterans' issues. The councils also include representatives from various Ex-Service Organisations (ESO's) and Defence Industry.

This submission

This submission was prepared through consultation with various members of the VAC and VHAC who have (or recently have had) high levels of exposure to those undergoing simple and complex transitions from the military to civil society. The phrase "complex transition" is used to express the experience of those who leave the military with physical, psychological, or social vulnerabilities, especially on an involuntary basis. The phrase "simple transition" is used to express the experience of those who leave the military voluntarily, with few or no health concerns. The submission also takes into account the Mental Health Prevalence (Van Hooff, Lawrence-Wood, Hodson et.al, 2018) and Pathways to Care (Forbes, Van Hooff,

Lawrence-Wood, et al., 2018) reports which are a part of the broader Transition and Wellbeing Study commissioned by Departments of Defence and Veterans' Affairs. Notably, the first of these reports suggest that almost 50% of those transitioned from the ADF experienced psychological disorder in the 12 months prior to participating in the research, but the latter suggests that only a quarter of these are engaged in evidence based treatment. The disparity between those experiencing disorder and those receiving treatment suggest some burden of service may be carried over to South Australia's social infrastructure and acute care services. For this reason, South Australia must be engaged and invested in veteran transition, especially as it applies to coordination between commonwealth, state, and local communities.

To assist the Joint Standing Committee on Foreign Affairs, Defence and Trade, address issues relating to the sensitive period of transition as it is reported to occur during and after service, this submission first situates the issues at hand in an historical context, and then explicitly addresses the areas of concern outlined in the Terms of Reference. A summary of key recommendations is located toward the end of the document, when addressing issues relating to optimal systems of care.

Historical context

The current inquiry into the transition experiences of veterans needs to be viewed in an historical context and in relation to the current models of health service delivery in and across transition from the military to the civil community. Currently, there are no longer any direct general or specialist medical assets that are under the management and direction of the DVA, which may otherwise act as a conduit for care for those who leave the military with complex needs. This situation contrasts to 1990 when every state had a veterans' hospital, which brought with it specialist staff in a range of medical and allied health domains that consolidated and represented generations of expertise in the care of veterans. Although there were some limitations with this service, including the fact that it did not explicitly account for transition experiences, it still embodied a group of medical and allied health specialists who understood the impact of service on the individual, and were thereby able to assist veterans and represent their needs, in a way that lay clinicians could not.

With the transfer and closure of the veterans' hospitals and movement to a purchaser-provider model, Australia is in a unique position of having a DVA that has largely divested itself of health assets and thereby some degree of continuity of care for those with complex needs. While the VVCS remains as a counselling service run by DVA, it does not have the positioning to identify, offer, or develop holistic medical and allied health services to the veteran community. This situation is in contrast to countries such as Canada and the United States, where veterans' health facilities remain.

In moving to a purchaser-provider model, included with private hospitals that previously were veterans' hospitals such as Greenslopes and Hollywood, there has been an increasing constriction of the services that will be reimbursed through these facilities with the reasonable justification of the application of treatment guidelines

and evidence-based care. However, it is important to realise that treatment guidelines have become an instrument of managed care which may limit culturally sensitive service provision that accounts for the distress that many experience when they leave the military.

Because evidence-based treatments used in civilian facilities are often developed for clinical populations who specifically and frequently exclude those with the experiences and comorbidities typical of veterans, they have limited utility. To highlight this disparity, there is significant and growing evidence that psychological treatments for PTS in veterans have worse outcomes than in civilian population groups. Treatments and guidelines based non-veteran experiences therefore, have questionable validity in the veteran health arena, particularly in relation to veterans who do not respond well to mainstream therapies. Some limitations of these treatments and guidelines are outlined below.

Line of inquiry: The model of mental health care while in ADF service and through the transition period to the Department of Veterans' Affairs.

Treatment response for PTS and improvements of treatment outcomes

The Pathways to Care Report released by the DVA (Forbes, Van Hooff, Lawrence-Wood, et al., 2018) reported that only 25% of those with disorder during transition were engaged in evidence based care, which raises concerns about the limitations of current therapeutic modalities endorsed by Defence and DVA, which are based on cognitive behavioural principles. Reflecting this concern, research has shown that cognitive approaches for military-related PTS is associated with high levels of non-completion, and low response rates. For example, it was reported that up to 70% of veterans who completed cognitive processing therapy retained a diagnosis, even when medication was used (Steenkamp, Litz, Hoge, & Marmar, 2015). The issue is that these approaches tend to be generalised, manualised, and focussed on the correction of personal cognitions and behaviours, without fully accounting for the individual, or the unique relationships (and the personal impact of them) forged in service. An understanding of these issues, which relate to identity, are critical for those working with veterans during the sensitive period of transition, which may go some way in shaping long term employment and mental health trajectories.

Notwithstanding this insight, there currently exists a gap between the health and mental health outcomes of veterans during transition and after service, and the ability to provide adequate care to better meet the needs of this population. This gap exists, in-part, due to a lack of a formally acknowledged theoretical framework that may otherwise help conceptualise it, provide a level of disciplined oversight, and thereby an ability to audit and critically analyse outcomes.

Limitations of the current services being provided by the private and state health systems

As suggested above, the DVA does not have a clear mechanism for responding to, or critically analysing clinical services. Nor does it have a mechanism to address

emerging concerns or advice provided from state based advisory groups. Considerable effort has been made in South Australia, through the establishment of the VAC and VHAC to help address the needs of those transitioning from service, and of veterans in the community. Despite these councils being in existence for several years, there has been little formal discourse between them and the DVA which highlights the disjunction between needs identified by the state, and the responsivity of the Department. This lack of discourse may be a result of the Department moving to the purchaser-provider model of care and the out-sourcing of services by Joint Health Command (JHC), through its relationship with Medibank Solutions.

There has been some progress towards improving state and commonwealth information exchange through the formation of the Veterans Ministers' Round Table (VMRT) supported by the Commonwealth, State and Territory Committee (CSTC). The VMRT's 2017 and 2018 theme has been transition and the CSTC has developed papers and agendas to assist Ministers' discussions on matters related to transition across the full spectrum of challenges faced by discharging defence force personnel.

The medical and Defence community recognises that the purchaser-provider model adopted by DVA and the outsourcing of services by JHC has served to fragment providers. This fragmentation is antithetical to the needs of those transitioning from service, many of whom would psychologically benefit from integration of services and the coherence it would help foster. This is particularly important for those who transition on medical grounds. Without such integration there is a constant problem about lack of continuity care and discontinuity of models.

In addition, the purchaser-provider model assumes there is clinical expertise within the broader community, which can be found by the purchaser, but it neglects the fact that throughout history, military and veteran health have irrefutably led and shaped care models adopted by civil society. *Major* advances in trauma care, acute medicine, mental health, and community health (including holistic models) have stemmed both from the battlefields and the health practitioners who have served in them. This degree of leadership and innovation depends upon the existence of an aggregated body of clinical and scientific knowledge that is sustained and supported within the veteran health care system, both within Australia and abroad. This often involves not only the development of new treatments for specific patients but the evolution of systems of care that are responsive to the changing needs of different generations of veterans. In the purchaser-provider model, there is no opportunity to advance medicine and healthcare in this way and as such, represents a devolution of care, rather than advancements in it.

Stemming from the issues outlined above, a significant limitation in services that many veterans currently experience, relates to the difficulty they have in finding clinicians who understand the demands of military service, the impact of these demands on the individual, and who share language to express and work through

the consequences of these experiences, on health and health behaviours. The Government of South Australia responded to this problem in 2016 by making a commitment to assist veterans (where possible) to access culturally relevant, coordinated and networked care (Government of South Australia, 2016).

Currently, culturally relevant clinical care can be found at the state level for those requiring inpatient mental health care at the Jamie Larcombe Centre, which is not however, currently coordinated with DVA's VVCS counselling service. Building on these services, the South Australian Government is developing an education module for all employees of SA Health, to help them better understand the needs of service personnel and veterans. In addition, a South Australian federation of private psychiatrists have formed the *Closing the Gap (CTG) Trauma Group,* who have voluntarily made a personal commitment to improving care for veterans and first responders by educating themselves in issues that are specific to this population. The CTG holds a relationship with the Adelaide Clinic and thus represents the shared identification of need (observed by both the public and private sectors) for veterans, to access clinicians with a degree of cultural sensitivity. Although these initiatives are promising, there remains a need to augment primary health services by way of networking adequately experienced or educated general practitioners and allied health professionals who are familiar with veteran and DVA matters.

Because this inquiry seeks to understand issues surrounding transition, and this particular line of inquiry relates to limitations of the current services being provided by health systems, some mention must be made of mental health services and expertise available *within* the military. As previously mentioned, the Pathways to Care Report (Forbes, Van Hooff, Lawrence-Wood, et.al., 2018) suggested serving personnel and those in transition have high rates of initial mental health service presentation, but only 25% of those with disorder were engaged in evidence based care. This raises concerns regarding limitations in the therapeutic services currently offered to military personnel in service, and after it.

At a strategic level, Australia is faced with the challenge of informing, coordinating and delivering mental health care services without any full-time uniform psychiatrists, which is unlike any other Defence Force of equivalent size nations. It is only in the last 6 years that a public servant psychiatrist has been employed in a Defence capacity. Similarly, within JHC there are no full-time medical specialists with mental health expertise. Instead of drawing on veteran specific expertise in various medical disciplines, Defence has depended upon the specialist reserves, who have little role in policy direction and service development. This means that JHC is not well placed to lead clinical development.

At a clinical level, the low rate of engagement in mental health support for those experiencing disorder, may be consequent to the fact that unit level care is provided by organisational psychologists who focus is recruitment and selection, training, organisational systems, along with testing and measurement (Department of Defence, 2018). Although organisational psychologists may provide counselling and

support, they are not trained in diagnosis or clinical care. Although there are clinical services within Defence, to which organisational psychologists can refer, soldiers, sailors, and airmen are generally not aware of the difference between these levels of training and the limitations they present. It has been reported by some service personnel who are currently in transition, that experiences of organisational psychologists in service, shaped what they felt psychology could offer in general, and this deterred them from engaging in therapeutic programs. This is concerning given the rates or disorder in this population along with low rates of therapeutic uptake in and around transition.

Waiting times and service limitations of the state systems, particularly mental health care for veterans

When people present to a health or mental health facility to seek support for psychological distress, it represents a fleeting window of opportunity for intervention. If immediate support is not forthcoming, the window often closes and the opportunity for intervention decreases overtime–usually with worsening symptoms and outcomes. Because of this phenomenon, the current South Australian Government made an election commitment to capture mental health statistics relating to waiting times and service limitations across all healthcare services, up to and including those relating to veterans' needs and services.

Regardless of what official statistics may reveal, it is well accepted that there is currently not enough psychiatric services to meet the current needs of veterans in the public and private sectors, and this is partly demonstrated by the formation of the CTG Trauma Group, described previously.

To mitigate issues of the provision of culturally sensitive care, and the limitations in the number of psychiatrists available to provide care in a timely manner, the University of Adelaide (School of Population Health) is currently developing Australia's first Graduate Diploma in Veteran and First Responder Counselling and Psychotherapy, with the aim to help close the gap between onset of symptoms or crisis, by providing a further layer of culturally sensitive support, informed by public health principles. This qualification will augment (but certainly not replace) the clinical care offered by general practitioners, psychologists and psychiatrists, and potentially provide a bridge to clinical interventions offered in these settings. The Graduate Diploma in Veteran and First Responder Counselling and Psychotherapy will be available in 2019 to clinicians, allied health workers, and to those with a service history (of any rank) who also have an aptitude for counselling and study.

The responsiveness of Defence and DVA to emerging international knowledge and the advice of health professionals consolidate that knowledge

Although the VAC and VHAC cannot comment on Defence and DVA's organisational knowledge, and thereby how they respond to such knowledge, there is no awareness of a framework or agenda (formally acknowledged by Defence and DVA),

which may otherwise link these organisations to each other, or to a broader research agenda or knowledge base. Rather, these organisations appear to remain invested in supporting modalities that treat symptoms directly (such as through manualised and generalised approaches) rather than contributing to, or engaging in, an overarching framework to help understand the cause of these symptoms. Such linkages would help consolidate international knowledge and translate it to clinical care, to support veterans during the sensitive period of transition. In addition, VAC and VHAC are not aware of research personnel within Defence or DVA with a recognised international peer reviewed academic profile, who can provide strong and clear expert advice about service delivery or innovation. This is necessary to develop and sustain relationships internationally with other professionals who are also invested in the wellbeing of veterans, and who may serve as important sources of insight and information.

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

The Government of South Australia identified a lack of coordination between the ESOs, DVA, and VVCS as a barrier to the ability for veterans (in-service or after it) to identify and engage support when they needed it, in 2016 (Government of South Australia, 2016). To address this problem, especially for those who most needed such support, the care model developed at the Jamie Larcombe Centre (JLC) included a Partnerships Hub which is a connective node that links ESOs to each other and to those most needing support. The Partnerships Hub is located in proximity of JLC, and staffed by a South Australian Government employee (himself a veteran) who coordinates, synthesizes, and facilitates relationships between community support services, veterans, and where indicated, current serving personnel. The Partnership Hub Coordinator also holds a very strong relationship with the Soldier Recovery Centre – Adelaide (SRC-A), which is an on-base, Army centric rehabilitation and transition centre. Together, these two coordinated nodes provide veterans and serving personnel a seamless knowledge of, and referrals to, the support offered by various commonwealth, state, and community organisations.

It is important to acknowledge that South Australia's partnerships Hub is associated with (but not exclusive to) those who access JLC for acute and respite services. Although early indicators suggest this model of community care helps to effectively engage veterans and service personnel at a time of increased vulnerability, the South Australian Government is committed to expanding this coordinated model to the wider veteran community, to help engage veterans more broadly. To achieve this engagement, a similar and more significant hub (in size and function) is being examined at the Torrens Parade Ground, which is a site of military significance in South Australia. The Torrens Parade Ground Hub will encourage cooperation, integration, and teamwork between all organisations that aim to support our veterans, at a strategic level. Together, the JLC Partnerships Hub (which caters to those with acute and respite care needs), the Torrens Parade Ground Hub (which will cater to the organisations that support veterans in the general community) and

the on-base SRC-A can facilitate many services within and between the ADF and civil community. Within the military, the key to success is the functioning of the SRC-A which holds relationships with those transitioning and their commanders. Within civil society, the key is provision of a coordinating and overarching body that can help veterans locate and access the care or support they need.

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

Current research agendas, therapeutic, and support structures remain fragmented between national, state, and local bodies. South Australia is committed to helping cohere these services to create a client centred and thereby holistic transition experience, at least for those who discharge to South Australia. These initiatives include programs that aim to support the identity of those undergoing transition from the military. For those with complex needs, the identity of the individual is upheld by cohering service provision in the community and at the clinical level. This is achieved by way of partnership hubs which coordinate with SRC-A, JLC, along with the education of all SA Health employees on veteran health matters. In addition to these initiatives, South Australia will be home to Australia's first graduate diploma program in trauma counselling and psychotherapy, offered through the University of Adelaide which will be designed with the needs of veterans in mind. Noting the importance of upholding identity by way of industry or work for those with complex and simple transition experiences, the VAC is working to facilitate relationships and thereby employment pathways between Defence and Defence industries, particularly for those who discharge on medical grounds, and who represent increased risk during transition (Van Hooff, Lawrence-Wood, Hodson et.al, 2018). Although these services are helpful to veterans at the state level, they would be optimally enhanced through national leadership in the following areas:

A transition framework recognised by Defence and DVA

The development of an overarching transition framework to help support these functions and inform care at the community and clinical levels, both in Defence and through DVA. The creation of an overarching transition framework will highlight gaps in care and clinical services, enable the critical analysis of these, and provide a means to identify veteran needs. Identification of these needs, against the backdrop of a framework, would help prioritise research agendas, which would in-turn, inform the education of military and veteran mental health and allied health professionals who can translate the research to practice, thus ensuring clinical standards and continuous improvement loops for care.

Some studies suggest that the transition from military service can lead to a downward spiral of social exclusion, homelessness, alcohol misuse, unemployment and poor mental health. Our transition services must be better equipped to assist those who have served to make this change. The point of 'handover' from the Department of Defence to the Department of Veterans' Affairs (DVA) should be clearly articulated. An individual should not be discharged until their entitlements, if

any, are determined by the DVA and DVA has all the necessary information it requires to assume the management of the individual. This is not to say that the individual abrogates all responsibility for their own welfare. It is simply to ensure that the service person, separating from their service family, is embraced in a similar way by their post service family.

There may also be a benefit in directing some research on examining the experiences, support systems, and motivations associated with differing experiences and trajectories during and after transition in each state. Such examination will give further insight as to how and why half of those transitioning do so with a strong foundation, despite many having exposure to significant stress and trauma during service. It will also help the States build more robust support systems during and after transition, and provide the military with insight that may guide their support systems over the same period.

Nationally mandate post-graduate education in Veteran Health and Mental Health

For the reasons outlined above there may some utility in nationally mandating post-graduate requirements for clinical staff who specialise in military and veteran mental health, to ensure issues areas of need adequately addressed in care settings. This may go some way in engaging and integrating VVCS with state services and community groups, such as ESOs.

Addressing issues of under-skilled mental health professionals in the ADF

A series of more specific information could be provided about the challenges and issues of the provision of services to veterans and currently serving ADF members and the continued under-skilling of mental health professionals in the ADF.

Sustained funding model for veteran health research and education

Further building on the above, there is a need for a sustained funding model to provide research and education and thus provide an academic voice that is independent of the often-complex political agendas attached to veteran health and mental health. In addition, such a model would also allow for further investigation into transition of Defence personnel, thus mitigating some neglect of this issue in the past due to competing political priorities of the major institutions involved. A capacity to independently critique and audit services without a conflict of interest or fear of having a funding cut is critical to the effective functioning of such groups, and more importantly, the health and wellbeing of the veterans who experience the tension of moving between them.

Transition Mindset

There is a current trend for transition to be considered towards the end of a period of service which may culminate, for some, as a crisis. Consideration should be made to frame transition from the ADF from the time that an individual enlists. This would ideally include consideration (and support) in exploring post-military careers or education. This change of mindset would ensure that an individual's period of service

is considered holistically from engagement to discharge and separation, and help motivate the individual to ensure his or her medical records, achievements, qualifications and transition processes are recorded and consolidated throughout a career, along with claims and entitlements through DVA if considered appropriate.

Help that makes sense from those who make sense: empathy, sensitivity, and recognition of service during transition

The Senate Inquiry into Suicide and Self Harm has revealed certain high risk groups which would be far better managed both administratively and morally if there was empathy, sensitivity and a recognition of good service during the transition period. Indeed, for some individuals transition is experienced as depressing, especially for those subject to involuntary discharge through wounding, injury or illness, and young people whose circumstances are not compatible with service who are administratively discharged within 12 months. In addition to building a transition mindset (outlined above) service personnel must have access to support that makes sense to them, by those who makes sense to them, when they need it.

To achieve this level of support Soldier Recovery Centres (SRCs) must have the best possible officers and NCO's allocated (for a period) to this task who have the necessary empathy and sound leadership qualities to manage these individuals through the traumatic transition period. Then having gained insight into the rehabilitation and transition experiences, these officers and NCOs (along with those who complete their rehabilitation and continue to serve) should take their new knowledge back to their units, who will then be better equipped to lead and support those still operating in that context. There was, for many years, what was termed "the rehabilitation platoon" which was considered an undesirable and stigmatised place, managed (in some cases) by individuals who resented being there and treated the transitioning soldiers accordingly, which may have had a negative influence on mental health. The ADF is an organization that prides itself on leadership in the battle space and it should be no different in the very sensitive area of transition and assisting as much as possible, individuals who have done their duty.

Complete medical records

During transition, processes must be put in place to ensure individual personal medical documents are intact, and the records and treatment of any wounds, injuries, sickness and illnesses obtained whilst serving in the ADF. In many cases the few serious issues that have caused major issues between the claimant and DVA in seeking entitlements has been rejected because a claim made for a particular injury is not recorded on the individual's medical files. When this occurs, the member will be financially disadvantaged and the state will be required to meet the cost of treating injuries and illnesses that may otherwise be attributable to the Commonwealth.

Families must be included in the transition process and seminars

Complex transitions can negatively impact the member's family, over and above the impact of functional limitations associated with physical, psychological, and social change. In addition, it has been noted that transition seminars are often not effective

because many transitioning members are looking forward to, and focussing on, the freedom of after-service life, without fully appreciating the issues they are likely to face. Because of these issues, partners or other nominated family member or close friend, should be included in the transition seminars to facilitate a balanced view of the process, enhance communication, re-enforce the availability of support, if the member should ever need it.

A staged and extended transition period

Numerous interviews with transitioning individuals of the ADF believe that the current three months transitioning period is too short for those with complex needs, or for those who have served for more than 15 years. Within the current three-month period match of the administration and planning is done under pressure, often whilst continuing their duties (even their duties in the field). Perhaps a more balanced approach would be to first assess if a member is likely to experience a simple or complex transition. If it is a simple transition, the first month may involve continuation in the role, at which time medical and DVA appointments can begin to be made, yet the member can continue to focus on the tasks of the ADF. This will also give the unit an opportunity organise a replacement, if possible. The second month might involve continuing in the role part-time whilst conducting a handover. It is during this time that medical appointments and other critical administration be completed. The final month will enable the member to participate in activities more orientated to interview and employment skills, along with addressing issues of social connection. It is important that this final month be conducted in the discharge location, because it represents a critical period to create social and employment networks. For those with complex issues, this whole transition period may extend to six months.

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

Veteran Internship

It is the opinion of the VAC and VHAC that a whole of government approach is the only way to facilitate the effective transition to employment for those who have served in the ADF and that transition should be aligned to supporting the future the member and their family choose. Whilst transition to employment may be less of an issue for those with a simple transition experiences, those with complex experiences may need opportunities to adjust to occupation in the civil industries. One way to achieve this may be through a commonwealth or government-supported 12-month veteran internship across multiple industries or levels of governance. Ideally this might involve three to four departmental rotations over 12 months, during which time a veteran would be afforded opportunities learn new industry language, to build relationships with others—and in doing so, learn more about themselves, and test their new reality (by way of limitations and potential). Ideally, such an internship would be characterised by opportunities for creativity, yet allow for mistakes to be made without judgment. For those with complex needs, those who undertake such an internship may be ideally supported by counsellors who themselves have a history of Defence service and transition.

Translation of qualifications

To enable transition to a veteran internship, further education, or employment, it is important that training completed in the ADF the translated and officially converted to a civilian equivalent throughout the period of service. This will ensure a better state of mind approaching discharge where the individual will have a suite of civilian qualifications that are more easily understood by a potential civilian employer or educational institution, thus enabling competitiveness in relation to civilian applicants. It will also curb the proliferation of companies who reportedly charge thousands of dollars to complete this task (at the member's expense).

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R.M. Manton
Director
Veterans SA
Executive Officer
Veterans' Advisory Council