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

Senate Standing Committee – Suicide by Veterans and Ex-Service Personnel

I am a currently serving ADF member. I have deployed on numerous occasions to ADF operational areas and undergone required psychological screening provided to deployed service-personnel. As such, I would prefer my submission be regarded as confidential.

I bring your attention to the mental health services provided to deployed ADF members prior to leaving an Area of Operations. Supposedly all members undergo a *Return to Australia Psychological Screen* (RtAPS) conducted by a suitably qualified Health Professional or Provider. Screening is mandatory but is often not supported by senior officers who see the process as a low priority. The most senior ADF members actively avoid RtAPS and need to be actively chased up. This sets a poor example and shows a lack of leadership and support for the mental health of ADF members. This poor example of leadership is highlighted by Major-General John Cantrell in his book "Exit Wounds" where he describes concealing his mental health issues because he feared adverse career prospects as a result. What are junior ranking ADF members expected to think of this example from a senior ADF officer?

Another psychological screen is required at a time after re-deployment to Australia; usually at a 3 to 6 month timeframe post deployment. This screen is termed a *Post Operational Psychological Screen* (POPS) and is conducted by a suitably qualified ADF Health Professional or Provider. Again, this process is ad hoc and often poorly supported by commanders; particularly RAN and RAAF. The outcome is that many members fail to complete this screen unless actively chased up, or are not appropriately assessed until many months (sometimes years) post deployment. Many ADF members (much like John Cantrell's example) fear adverse career progression if mental health issues or risks are brought to the attention of the ADF.

One of the purposes of psychological screening is early identification of ADF personnel who may be at risk of developing mental health issues as a consequence of experiences while deployed, or during homecoming post-deployment. Of concern is the qualification of those providing this screening. Usually the screen is conducted by a Uniformed Psychology Officer or a Soldier with a trade qualification of Employment Category Number (ECN) 131 (Psychological Examiner). This trade is the only defence health trade without any requirement to adhere to Australian Health Practitioner Regulation Agency (AHPRA) registration requirements, nor is there any requirement for currency trade training for ECN 131. Additionally, it is the only defence health trade without any civilian recognition of proficiency. Of note is that this trade has one of the highest pay grades in defence, but one of the lowest training requirements of any ADF trade. Unlike most other ADF trades, ECN 131 has not been before a pay-grade tribunal since the mid 1970s. The adequacy of Psychological Examiners providing psychological screening is questionable if based on training and qualification. Risk mitigation, such as supervision by a Psychology Officer, appears to be poorly administered and is not an adequate risk mitigation procedure for identifying "at risk" individuals.

There also appears to be a poor use of qualification and service provision in the use of uniformed Psychology Officers. Many Psychology Officers make use of defence entitlement

to extend their professional qualification through approved Long Term Schooling (LTS) of up to 12 months, and defence paid professional development opportunities. As part of the current normal career progression of Psychology Officers, the most qualified are posted into administrative positions in Canberra where they have minimal contact with defence clientele. Others are posted into command positions – usually the realm of General Service Officers who have graduated from Officer Training (ADFA or Duntroon) - not Special Service Officers commissioned for their professional trade rather than attendance at officer training facilities. There is a training disparity where our best qualified uniformed psychologists are not utilised in service provision to a client load; client services are the realm of the least qualified of our uniformed Psychology Officers. ADF members deserve better.

ADF members who self identify as having a mental health issue are subject to unacceptable waiting times to access either an ADF Psychologist or Medical Officer. Health resources in terms of staffing are inadequate on most (if not all) military bases. Members with mental health issues are often referred out to civilian agencies for treatment because ADF does not have the resources to provide adequate services. ADF makes use of the DVA entitlement for veterans to be treated by mental health services through agencies such as VVCS. Veterans often feel belittled or palmed off by defence in that this referral to non-defence providers appears to be the default option. Veterans feel like they have been deferred to the too hard basket.

In 2009 a review of mental health care in the ADF was conducted by Professor David Dunt. This review provided 52 recommendations, most of which were accepted by the ADF. A multimillion dollar budget was allocated to implement the recommendations but no serious audit of this budget expenditure has been conducted. Funds were spent on the purchase of a semi-trailer load of stress balls, Frisbees and other promotional products. More funds were spent on senior officers travel expenditure to attend 'meetings' and conferences with little to no outcome. The employment of actual mental health professionals as recommended by the Dunt review did not transpire as expected – particularly in regions such as Townsville and Darwin where the bulk of the defence force, and therefore client load, are located.

In regard to transition out of the ADF, there is no provision of exit mental health services. Defence provides a 2 day transition seminar covering an abundance of topics on an optional attendance basis, but there are no mandatory mental health services to determine suicidal risk or otherwise. Once discharged, there are no ADF services available, and services by external agencies are inadequately defined in ADF policy and doctrine on the basis that it is not an ADF concern or responsibility. It is difficult for discharging ADF members to source information regarding services available to them post-discharge. Once discharged it even more difficult to access information about available mental health services – particularly for those suffering a mental health issue impacting upon their functioning.

On a separate note, I wonder why ex-service organisation advocates are required for dealings with DVA. Shouldn't DVA be the advocate for veterans? DVA has gained a reputation for being essentially an insurance provider for the government with a reputation for excessive documentation and obstacles to entitlements rather than provision of assistance. This must change.

Sincerely,
Name withheld.