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Mental Health Concerns

5.1 This Chapter concentrates specifically on mental health issues in the Australian Defence Force (ADF). The issues addressed include post-traumatic stress disorder (PTSD) as well as broader mental health concerns, anxiety and depressive disorders generally, and substance abuse. In this Chapter the Committee considers psychological rehabilitation support provided to wounded and injured veterans and their families, and describes an Army initiative that combines physical and mental rehabilitation.

5.2 The Chapter also considers how mental health fits within Australian military culture.

Mental health in the ADF

5.3 Professor David Forbes, the Director of the Australian Centre for Post-traumatic Mental Health (ACPMH) advised the Committee that mental health, in reality, is a continuum and that part of the legitimisation and understanding of mental illness in the wider community is to understand that mental health is a continuum around which all people fluctuate.[1]

5.4 Professor Sandy McFarlane AO told the Committee that the *2010 ADF Mental Health Prevalence and Wellbeing Study* showed that in a 12-month window in 2010, 22 per cent of the members of the Defence Force were suffering some form of psychiatric disorder. He advised the Committee that this percentage was probably an accurate representative figure of psychiatric disorder levels in the ADF at any one time. He also said that

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1 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 13.

based on this and other studies, over their life time, 54 per cent of ADF members will have had a psychiatric disorder.[2]

5.5 Defence advised the Committee that there were insufficient numbers of Special Forces (SF) participants to allow prevalence rates of mental health disorders within that sub-group to be estimated. The Middle East Area of Operations (MEAO) census study report and the MEAO prospective study reports do not include analysis of subgroups such as SF within the ADF. Defence indicated, however, that initial analysis of the mental health symptoms measured across all three studies has indicated that the SF population is only slightly healthier than the broader Army population despite the high operational tempo.[3]

5.6 Professor McFarlane gave evidence that rates of depression in the Defence Force are 6.4 per cent compared with 3.1 in the broader Australian community, and that the rate of PTSD in 2010 was 8.3 per cent compared with 5.2 in the general community. Professor McFarlane said that this means that the ADF has a much higher burden of mental illness than the general community.[4]

5.7 Dr Andrew Khoo, the Clinical Director of Group Therapy Day Programs at Toowong Private Hospital (TPH) advised the Committee that while PTSD has received significant attention recently, the most common outcome of significant trauma is not PTSD; it is actually depression or, even more frequently, substance abuse:

> Substance abuse, depression, and other anxiety disorders are more common than is PTSD.[5]

5.8 Dr Glen Edwards, when interviewing Vietnam veterans, found that many of them had seen or were seeing mental health professionals, not so much for PTSD but mainly for depression or relationship difficulties.[6]

Post-traumatic stress disorder

5.9 Dr Khoo explained that PTSD is a psychiatric condition that occurs as the result of significant trauma — typically a life-threatening trauma. He advised that anybody who has been involved in military service, particularly overseas operational service, often easily meets that criterion.

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2 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 2.

3 Department of Defence, *Submission 38*, p. 1.

4 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, pp. 2, 6.

5 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 17.

6 Dr Glen Edwards, *Committee Hansard*, 8 February 2013, p. 8.

5.10 Dr Khoo summarised the symptoms relating to PTSD:

- An individual re-experiences that trauma in the form of thoughts, images, nightmares and/or flashbacks;
- They develop a pattern of avoidance in order to avoid any trigger that might remind them of that trauma; and
- An individual spends a large proportion of the time constantly physically hyper-aroused — shaking; sweating; increased heart rate; increased respiration rate; abdominal symptoms — and being psychologically hyper-aroused — insomnia, irritability, impatience, intolerance and hyper-alertness.[7]

5.11 Associate Professor Malcolm Hopwood, the Clinical Director of Austin Health's Psychological Trauma Recovery Service (PTRS), told the Committee that the clinical definition of a disorder is a 'set of signs and symptoms that causes functional impairment' and that the debilitating effects of post-traumatic stress are indeed a disorder. He advised that PTRS data shows that following Vietnam, as many as one in four individuals suffered PTSD and in about half of those — one in eight — it went on to become an ongoing, chronic mental health problem; a clinical disorder. He did however acknowledge that it is a 'very dangerous thing' for any individual to become defined by that diagnosis.[8]

5.12 Dr Khoo advised the Committee that the main issue regarding PTSD is that it is typically very difficult to treat. Drug therapy treatment solutions for PTSD are not as well understood compared to that for other psychiatric disorders. He advised that the real cornerstone of treatment for PTSD is psychological therapy called cognitive behaviour therapy (CBT). Use of CBT has been shown to be the most efficacious treatment for the disorder.[9]

5.13 Dr Khoo's written submission advocates for a CBT-based psychotherapeutic approach to trauma-related mental illness. This is seen as a primary therapeutic approach which may or may not require augmentation with pharmacotherapy. Evidence would also promote this approach (that is, CBT with or without medication) for dealing with other anxiety disorders and depressive disorders.

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7 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 11.

8 Associate Professor Malcolm Hopwood, Clinical Director Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 5.

9 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 11.

5.14 Dr Khoo advised that 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 psycho-education, psychological first aid (PFA) and trauma risk management (TRiM) aim to improve identification of psychopathology and self-referral.[10]

5.15 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 there are conflicting views as to the efficacy of mandatory debriefing-type interventions, the literature is consistent with regard to the benefits of early intervention once PTSD or another mental health condition has been identified.

5.16 The United States (US) Department of Defence Guidelines for the Treatment of PTSD identify that the biggest difference to treatment outcomes can be made by identifying individuals with disorder and maintaining them in treatment. The Guidelines stipulate that, even though the official title is 'Treatment of PTSD', they should be taken to include treatment of depressive disorders, anxiety disorders and substance misuse, not just PTSD. Ideally treatments should be evidence-based and comprehensive, addressing biological, psychological and lifestyle elements. Where possible the use of multi-disciplinary input is optimal.[11]

5.17 Dr Khoo submitted that a nation sending young men and women overseas where many will become permanently injured and some will not return, needs to make 'hard decisions' regarding funding the best possible care for them on their return.[12] This is particularly telling noting that the Committee heard that, regrettably, some veterans with diagnosed PTSD and other major depressive disorders are given no support.[13] Major General (MAJGEN) (Retired) John Cantwell AO DSC, in his testimony, which the Committee found particularly compelling, said:

> PTSD is a potentially fatal illness. It leads potentially to suicide, self-harm, aberrant behaviour and ruined lives. It is one that deserves close attention. Given the numbers of veterans that Australia has through our wars of late, and over the decades before, it is an issue which is certain to grow in its reach and in its

10 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 5.
11 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 5.
12 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 5.
13 Name withheld, *Submission 14*, p. 2.

> implications for veterans' support by government, private agencies and the community in general. It is a very, very important issue.[14]

5.18 An additional concern is the effect of physical injuries on the mental health of an individual:

> The physically wounded … have a special sort of pain and difficulty to deal with, but the emotional one is much more insidious and much more difficult to deal with and causes much more confusion in the mind of not just the veteran and all those surrounding them.[15]

Defence culture

5.19 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health Command, gave evidence that within both the civilian community and Defence there is a stigma about mental health disorders, but that Defence is trying to recognise and understand what that stigma means.

5.20 RADM Walker said that there is a concern amongst Defence members that a recognised mental health disorder may prevent a member deploying. She noted Defence's occupational health and safety responsibility to make sure that people are fit to do the job they are doing, and said that it is a matter of trying to identify people at risk of PTSD and other mental disorders, and trying to get people to seek treatment early.[16] 'Soldier A' told the Committee:

> I think it is part of the Army culture. I do not blame anybody. I was the same when I was younger, when I first joined up, before I had an understanding. Maybe guys need to understand. … They do not know me specifically; they just see a broken corporal.[17]

5.21 The Legacy Australia Council (Legacy) submitted that overcoming the stigma associated with mental health issues, and normalising both the existence and treatment of mental health needs to be addressed. MAJGEN Cantwell also made this point in his testimony.[18] Legacy noted that there have been attempts overseas to characterise mental health issues not as a disorder (for example, PTSD), but as a battlefield wound or operational injury.

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

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

16 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 9 October 2012, p. 2.

17 Soldier A, *Committee Hansard*, 25 October 2012, p. 2.

18 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 7.

5.22 Legacy submitted that such an approach to terminology would help to normalise mental health wounds and injuries as part of battle, and be perceived as more honourable and easier to accept than something termed as a 'disorder'. They submitted that this could also assist families to convince their veteran partner to seek treatment and support as required. Legacy suggested terminology such as 'Battlefield Stress Wound', or 'Operational Stress Injury'.[19]

5.23 Soldier On also aims to help to de-stigmatise post-traumatic stress:

> Hopefully, as I said, through calling it [post-traumatic stress] and through working on de-stigmatisation, guys will be able to say, 'I just need a hand,' and then go and get that help.[20]

5.24 Dr Khoo submitted that it is a recognised phenomenon (and a recurring theme) that there is a stigma and denial around mental illness in the male-dominated military culture.[21]

> Weakness it is not tolerated and strength is celebrated, just as much physically as mentally. … Fewer than 50 per cent will nominate that there is something wrong with them.[22]

5.25 Similarly, Dr Glen Edwards believed that this attitude is imprinted consciously and/or subconsciously on individuals during training and service and that as a result, ADF and ex-service personnel are good at hiding and burying their true emotions and feelings, particularly to outsiders. The presenting problem is therefore often not the actual problem. Prejudice and stigma assist in delaying the individual from seeking assistance for mental health issues and that therefore confidentiality is often the single most important issue preventing the individual from doing so.[23] Professor McFarlane told the Committee that soldiers are trained to ignore physical hardships and fear.[24]

5.26 PTRS also submitted that there is an ongoing concern amongst service personnel that declaration of a disorder may lead to the end of their military career or at least being ostracised by their peers. They submitted that continued efforts to recognise the inevitability of such difficulties for

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19 Legacy Australia Council, *Submission 12*, pp. 4-5.

20 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, pp. 2, 6.

21 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 12; also Name withheld, *Submission 6*, p. 1.

22 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 12.

23 Dr Glen Edwards, *Submission 34*, pp. 2-3.

24 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 5.

some on operational service would aid effective early identification and intervention.[25] Professor Hopwood stated that:

> I think critical to improving the chances of getting people to acknowledge mental health disorder earlier is to establish that, if that is identified, firstly, it does not mean the end of their career in the ADF. It may mean that it is not appropriate for them to go on the very next deployment — and that is tough; they clearly have a commitment to their peers — but it does not automatically mean the end of their career. We need to continue to work to reduce the stigma associated with acknowledging mental health disorder.[26]

5.27 Unfortunately there remains an attitude amongst some Defence members that, 'despite the rhetoric', the ADF remains incapable of adequately dealing with those suffering psychological trauma and that those with psychological injuries are treated as 'damaged goods', and either managed out of the Services or otherwise not adequately taken care of.[27] General Cantwell put the point forcefully:

> There is a degree of ignorance and fear and shame attached to this inside the suffering individual's mind. There is also a degree of fear and ignorance in the organisation. We understand — when I say 'we' I mean the soldier fraternity, the military fraternity — understand physical wounds. We get those. They are a badge of honour in many ways. What we do not find 'normal' is someone … who … becomes a gibbering idiot.[28]

5.28 General Cantwell told the Committee that he felt that mental health is not well understood organisationally within Defence, is not part of the culture and even disdained. Defence culture expects people to be robust physically and mentally, and expects those in combat to be particularly 'rough and tough and resilient'. He gave evidence that the problem is that the warrior ethos does not translate into an attitude that allows an individual to seek help, to say they are depressed: 'The system does not respond to it.'[29]

5.29 General Cantwell felt that although the local medical officer, psychologist or Commanding Officer might be sympathetic, the Defence organisation has not yet made the transition to deal with emotional wounds in the same

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25 Psychological Trauma Recovery Service, *Submission 24*, p. 4.

26 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 3.

27 Name withheld, *Submission 16*, pp. 6-7.

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

29 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 3.

way that it does physical wounds and that Defence has a long way to go to overcome it.

5.30 General Cantwell did feel that Defence has 'got smarter' at dealing with the mental health issue and that there is a greater understanding, awareness and sympathy, however the problem is that the target audience, mostly young males, are exactly the wrong group to expect to open up and talk about their emotions.[30] Commodore (CDRE) Peter Leavy, Director General Navy People, told the Committee:

> There is a long way to go; there is still an element of stigma, I would suggest. But, personally, I think we have made quite significant inroads in breaking down the barriers that were there even 10 years ago.[31]

5.31 The Committee heard evidence the Army is likewise also attempting to change the culture surrounding mental health:

> We brought together senior Army commanders and persons who were suffering, and their families, who were prepared to engage with us. It is a very positive next step leading to initiatives about how we might further advocate and encourage individuals, where they feel comfortable to do so, to be advocates to break down the stigma.[32]

> There is a great deal of attention across our levels of command and in our training institutions to be aware of the reality of [mental illness] and to acknowledge it as like a physical injury, something that requires attention, maybe more complex and takes longer, but is equally repairable and has both an individual's responsibility and an organisation's to attend to the needs of the individual and the safety of the team.[33]

5.32 Defence has acknowledged that operational experience continues to demonstrate that PTSD can develop in otherwise highly functioning people. The 2013 Defence White Paper says that ADF personnel are considered a high-risk group due to their involvement in challenging combat, peacekeeping and humanitarian deployments.[34] General

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30 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, pp. 3, 5, 9.

31 CDRE Peter Leavy, Director General Navy People, *Committee Hansard*, 9 October 2012, p. 4.

32 MAJGEN Angus Campbell AM, Deputy Chief of Army, *Committee Hansard*, 9 October 2012, p. 4.

33 MAJGEN Angus Campbell AM, Deputy Chief of Army, *Committee Hansard*, 19 March 2013, p. 7.

34 Department of Defence, *Defence White Paper 2013*, p. 105.

Cantwell told the Committee that he was able to bury it 'really deep inside' and that allowed him to continue to function effectively.[35]

5.33 Nonetheless, not every experience is the same:

> Personally, I do not feel stigmatised. If anything, my direct core of people respect me a little bit more because of what I have done in getting out there and doing this.[36]

5.34 The Returned and Services League of Australia (RSL) Queensland Branch submitted that it appears that there are 'many' ADF members who are transitioning out of the ADF with psychological injuries. These members do not wish to advise or admit to Defence that they may be suffering a psychological injury as a result of their operational service, or they use the Veterans and Veterans Families Counselling Service (VVCS) because they know that the ADF cannot obtain reports from VVCS.[37] One soldier made the point succinctly:

> Australian soldiers will hide if they are injured and need help. It is the way soldiers are… [it's] a bloke thing and an Australian thing.[38]

Female veterans

5.35 Arguing that appropriate gender-specific research is lacking, the RSL South Australia submitted that research is particularly required to ensure that female veterans have access to appropriate support.[39]

5.36 Associate Professor Susan Neuhaus CSC told the Committee that the contemporary female veteran group believes that there are barriers to care. Furthermore, female veterans are less likely to access veteran specific health services, or to believe that they have a legitimate right to do so. She told the Committee that Sergeant Sarah Webster, who was seriously injured in Iraq as a result of conflict related injuries and who not only rehabilitated but returned to a subsequent tour of Afghanistan, has spoken publicly of being in a forum with other wounded soldiers and feeling that she lacked legitimacy, that she had no right to be there, and of others' assumptions that she must just be a girlfriend or a member of staff.

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35 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 3.

36 Sergeant (Sgt) Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 26.

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

38 Soldier A, *Committee Hansard*, 25 October 2012, p. 2.

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

5.37 Professor Neuhaus commented that on one level this is an education and awareness issue, but on another it impacts on equity of access to services:

> If you do not see yourself as a legitimate veteran and if others do not see you as a legitimate veteran, it makes those barriers much harder for you individually or for your family to reach into the services that may be best to meet your needs.[40]

5.38 Other than Professor Neuhaus, the Committee did not hear any direct evidence from female veterans wounded or injured. Professor Hopwood advised the Committee that PTRS' experience is that, tragically, the most common form of trauma experienced by women within the ADF is sexual-abuse related.[41]

5.39 The Committee notes the recently released Australian National University (ANU) report into *The health and wellbeing of female Vietnam and Contemporary Veterans* with Dr Samantha Crompvoets as the Principal Investigator. The report lists the barriers to accessing existing services for female veterans as:

- Lack of authentic veteran identity;
- Lack of trust in the confidentially of DVA/ADF funded services;
- Stigmas associated with mental health issues and treatment;
- Lack of trust in the DVA 'system' of claims processing;
- Disconnect between information given at the time of transition and perceived/actual time of needing this information;
- Perceived and/or experienced lack of understanding from others about issues relating to discharge or deployment; and
- Perceived and/or experienced lack of understanding from others about issues relating to maternal separation and parenting.

5.40 The report also lists significant gaps in available and appropriate information, resources and DVA polices for female veterans:

- Perceived lack of support services developed for or targeted at female veterans;
- Lack of resources for facilitating continuity of learned coping strategies;
- No resources, information or DVA policies relating to military sexual trauma; and
- Lack of appropriate information on female specific issues including maternal separation, reproductive and gynaecological health, domestic

40 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, pp. 16, 18.

41 Associate Professor Malcolm Hopwood, Clinical Director Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 6.

violence, lesbian, transgender and same sex attracted women, and military sexual trauma.

5.41 Finally the report identifies the gaps in knowledge of female veterans that impact health and wellbeing and service provision as being:

- Perceived limited understanding of trauma exposure experienced by their civilian and DVA service providers; and
- Significant gaps in evaluation and best practices and best practice guidelines of health care provision for female veterans in Australia.[42]

5.42 The report recommends that DVA:

- Develop targeted support and resources for female veterans;
- Increase the visibility of services for and experiences of female veterans;
- Facilitate continuation of applying coping strategies post-discharge from the ADF;
- Implement and evaluate family friendly practices;
- Provide training to civilian health care providers on issues for female veterans; and
- Set a strategic research agenda on female veterans' health.[43]

Defence hierarchy attitude

5.43 General Cantwell told the Committee that it is a measure of great leadership if a commanding officer can understand what his/her soldiers are going through and is able to articulate to them in a way that lets them understand that they care. General Cantwell believed that any commander at any level, whether it is a sergeant or a general, who suspects that their people are emotionally damaged and are likely to suffer further damage, would not continue to do that if given the choice. A good, sympathetic, well-informed and enlightened chain of command might enable an individual to step forward to seek help. However he advised the Committee that he knows 'one or two' commanders who do not believe in PTSD.[44]

5.44 The Committee heard similar evidence that different levels within Defence hierarchy have differing opinions on the effects of PTSD:

> I was originally on a four-hour return to work program, which was not going to well. There was a lot of aggression and shoving

42 Dr Samantha Crompvoets, *The health and wellbeing of female Vietnam and Contemporary Veterans*; p. 22.

43 Dr Samantha Crompvoets, *The health and wellbeing of female Vietnam and Contemporary Veterans*; p. 35.

44 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 10.

> from seniors. They were incapable of dealing with such problems.[45]

5.45 The Committee received a submission describing an instance where, despite support from immediate superiors, administration officers refused to acknowledge that an operationally caused mental health condition could be a factor in an administrative decision (particularly with respect to the interpretation of the ADF Pay and Conditions Manual (PACMAN)), despite the submission of a formal Redress of Grievance and the involvement of the Defence Force Ombudsman. The member eventually needed the direct intercession of the Chief of the Defence Force (CDF) to have his claim approved however the unnecessary stress directly detracted from the members' recovery and he was eventually discharged medically unfit for service.[46]

5.46 RADM Walker acknowledged the broad issue:

> It is about improving mental health literacy … all through command at the different leadership levels, about getting people to understand what a mental health disorder is.[47]

Confidentiality

5.47 Dr Khoo submitted that there is a pervasive suspicion that military health personnel are not bound by the same confidentiality constraints as their civilian counterparts. Many servicemen/women fear the impact that disclosing psychological injury will have on their ongoing employability, deployability and promotional opportunities. He submitted that an ongoing, predominantly internal (that is, an on-base ADF management) approach to treatment will remain a significant barrier to early identification of psychiatric illness.[48]

5.48 General Cantwell told the Committee:

> I am willing to state that I believe it to be the case that people are disadvantaged if they step forward. I certainly, over many years, formed a firm view that if I stepped forward and was honest about my own situation, that it would cost me. I am sure that I was right in that view.
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> We have wonderful people in the Defence Force and there are so many people competing for a small number of top jobs. … We have the advantage of choosing from a terrifically well-trained,

45 Soldier F, *Committee Hansard*, 25 October 2012, p. 8.

46 Name withheld, *Submission 6*, p. 1.

47 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 9 October 2012, p. 2.

48 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, pp. 3-4.

> motivated and very able workforce,… promotion and the next good job and the next deployment overseas are down to very fine distinctions. You are choosing between 'wonderful' and 'excellent'. Any question mark is a reason not to select, in many cases.[49]

5.49 Defence does not routinely compare the rates of promotion of military personnel who have been wounded or have suffered PTSD against those who have not.[50]

5.50 Lieutenant Colonel (LTCOL) Michael Reade, the ADF's Professor of Military Medicine and Surgery advised the Committee that Defence medical officers are often required to make it explicitly clear to patients that they are treating them not only as a clinician, but also as an agent of the organisation in which they both serve.

5.51 LTCOL Reade did not believe that this apparent contradiction is as problematic as it might seem. He assured the Committee that a member's chain of command does not have full access to the medical file; it is medical-in-confidence. A Commander is permitted, however, to ask the managing medical officer, 'What's going on?' LTCOL Reade believed that a knowledgeable service doctor taking charge of the patient's case, discussing the occupational implications of the case with the treating psychiatrist, and filtering that information back to the chain of command is the optimal solution.[51]

5.52 Professor Forbes gave evidence that Defence does send the correct message in relation to acceptance of mental health, and in relation to ensuring mental health is recognised as something that can be addressed and treated and that is not necessarily going to have an impact on career and postings. He noted, however, that there is also the reality that if a mental health condition is severe and requires prolonged treatment, to protect the serviceman and others it would be likely that there would need to be an impact on postings. He went on to say that there may therefore be some justifiable limitation on a member's career.

> I know that a significant proportion of current Defence members self-refer to Veterans and Veterans Families Counselling Service to get help and support for reasons of keeping Defence blind to it.[52]

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49 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 8.

50 Department of Defence, *Submission 37*, p. 1.

51 Lieutenant Colonel (LTCOL) Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 29.

52 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 13.

5.53 RADM Walker advised the Committee that under the medical employment classification (MEC) system, if Defence is aware of people who have symptoms of PTSD or other mental illnesses, they can be diagnosed and receive a treatment program. She advised that there are obviously restrictions placed on those individuals in terms of their deployability, access to weapons and other occupational restrictions, but that it is the same process used for physical illnesses and conditions. She advised the Committee that limiting employability on an as-required basis is about ensuring Defence's duty of care to the individual, the organisation, and to their colleagues, and to allowing people the time, where possible, to recover from their treatment and, if possible, remain in service.

5.54 Commander Joint Health told the Committee that previously if an individual was not fit to deploy within 12 months they were discharged. Now it is a flexible, individual arrangement which attempts to balance the individual's desires, their clinical requirements, and the organisation's needs. She highlighted that the system is now individually based, but maintained that the system is there to protect the rights of the individual, and the organisation.[53]

5.55 Professor McFarlane highlighted that there are many people who, hiding significant symptoms and disorder, have had very distinguished military careers but that there is a risk to those individuals of continued, prolonged exposure in the deployed environment making their condition more severe and more chronic.[54] Dr Khoo told the Committee that there needed to be greater separation between the treatment and the employer and that Defence is not equipped with the appropriately qualified psychologists to treat PTSD sufferers in any great numbers.[55]

Psychological rehabilitation

5.56 Professor Hopwood said that PTRS consider that mental health disorders rank alongside physical health disorders in order of severity, significance and frequency, and that therefore it is important to ensure that mental health problems are detected and managed in an effective manner. It was agreed that screening for pre-existing disorders prior to overseas deployment, detection of mental health disorders following deployment,

53 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 201, p. 6.

54 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 6.

55 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, pp. 14-15.

and effective management when a disorder is detected are all therefore very important.[56]

5.57 Defence has a limited number of uniformed psychologists and RSL Queensland expressed concern that Defence budget reductions have caused Reserve Psychologist training days to be reduced and that this has had a direct impact on the psychological service being provided by ADF.[57]

5.58 Air Marshal Binskin responded that:

> In general, with the budget, as we look for the savings we prioritise, and clearly [psychological rehabilitation programs] are high on the priority list.[58]

5.59 Defence went on to submit that budgetary restrictions have not impacted the provision of health care services to ADF personnel and there has been no reduction to health capability as a result of the budgetary pressures facing the Department.[59]

5.60 Further, Defence submitted that on-base mental health teams consist of ADF personnel, Australian Public Service (APS) personnel and contracted personnel engaged as social workers, psychologists and mental health nurses. In support of the on-base Mental Health Team, off-base service providers are utilised on an as-required basis, as deemed clinically appropriate.

5.61 The actual number of contracted personnel in the on-base mental health team has increased slightly subsequent to the transition to the new ADF Health Services contract. The total number of mental health professionals engaged prior to the new contract was 32 full time equivalent (FTE) positions and post the new contract is 36 FTE. Psychologists made up 17.5 FTE previously and now make up 18.5 FTE of the total numbers of mental health professionals respectively.[60]

5.62 Prior to the new garrison health support contract with Medibank Health Services (MHS), Defence did not have formal agreements with any off-base health care providers and services were sourced via any registered health professional within the civilian community on a clinically appropriate basis. Under the MHS contract Defence can still access any registered health professional within the civilian community, however,

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56 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 1.

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

58 Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force, *Committee Hansard*, 9 October 2012, p. 7.

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

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

Defence now has access to a list of 176 psychiatrists and 920 psychologists who are pre-credentialed and approved with MHS.

5.63 In recognition of the varying clinical requirements and changing geographical requirements of the ADF, Defence submitted that they will continue to work with MHS throughout the contract term to ensure ADF personnel have access to appropriate care.[61]

5.64 PTRS submitted that health services across the ADF relevant to mental health care are not well integrated and that there is a particularly troubling operational distance between primary care, psychological services and specialist mental health support.[62]

5.65 Young Diggers submitted that the psychological care provided by most units in the ADF is appalling. Young Diggers' primary concern was that ADF mental health units are still treating young members the same way that they treated Vietnam War veterans, implying that nothing has changed since.[63]

5.66 ACPMH highlighted in their submission the importance of the mental health service delivery system being adequately resourced to provide a genuine, tailored response to an individual's identified needs.[64] Professor Forbes

> There is something unique about military service as well as military experience … the nature of event that you experience … [that requires] a very tailored and targeted intervention.[65]

5.67 The 2013 Defence White Paper states that, acknowledging that awareness of mental health is a key factor in preventing future problems, the Government has directed work to identify opportunities for enhancements to current programs across all levels of the ADF and at all stages of an ADF career. The White Papers says that this will help to ensure that ADF members and their families are aware of the risks associated with mental health disorders and are encouraged to seek help early and that it will also ensure that appropriate support is in place and available once sought.[66]

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61 Department of Defence, *Submission 38*, pp. 7-8.

62 Psychological Trauma Recovery Service, *Submission 24*, p. 3.

63 Young Diggers, *Submission 22*, p. 1.

64 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 2.

65 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 11.

66 Department of Defence, *Defence White Paper 2013*, p. 105.

Antidepressant medication

5.68 Dr Khoo gave testimony that he is encouraged that the ADF had reconsidered their stance on the deployability status of members on antidepressant medication, noting that the majority of newer antidepressants are very well tolerated, widely prescribed and utilised, and allow an individual to operate at full capacity in any number of occupations.[67]

> I am on a journey of recovery where I have been given some excellent care, some medication, a loving wife and a determination to get better.[68]

Family support

5.69 In 1999 DVA published a study into Vietnam Veterans Health that examined the effect of veteran health on the health of their partners. The study found that 36 per cent of veterans reported health problems arising as a consequence of their service in Vietnam, and that some 40 per cent of those reported physical or psychological health problems in their partners that they felt were related to their Vietnam service.

5.70 This study highlights the importance of ensuring that adequate proactive access and support is made available to partners and children of current serving personnel (as well as veterans of all conflicts).[69] One soldier diagnosed with PTSD commented on his family's experience:

> We are not really satisfied with the level of counselling for the children. My youngest daughter has seen what is going on with me and does not understand, so she has developed oppositional defiance disorder. … [My wife has] not quite been satisfied with how comfortable she feels with them.
>
> In moving forward, children are going to make up a high percentage of the cases. When we look at the suicide rate of children of Vietnam veterans, for example, we see that it is high and we know that many children of Vietnam veterans have had mental illnesses.[70]

67 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 4.

68 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 2.

69 Name withheld, *Submission 5*, p. 6.

70 Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 26.

5.71 The Committee was informed of two recent veteran health studies relating to families conducted by Centre for Military and Veterans' Health (CMVH):

- The Timor-Leste Family Study, designed to investigate the effects of recent deployments to Timor-Leste on the health and wellbeing of ADF families; [71] and
- The MEAO Health Study designed to investigate the health of ADF members who have deployed to the MEAO, with a view to identifying factors associated with poorer or better health which is currently concluding. The preliminary findings are under active consideration by Defence and are due to be released in the coming months.[72]

5.72 CMVH reported that most of the results of the MEAO Health Study were as expected from previous Australian studies (including the *2010 ADF Mental Health Prevalence and Wellbeing Study*). There were strong associations between perceptions of high levels of unit cohesion, military, family and community support during and after deployment, and good mental and general health. Patterns of symptoms were similar for people who deployed to Iraq or Afghanistan, and similar to patterns reported for other deployments.[73]

5.73 CMVH's Timor-Leste Family Study (TLFS) compared the health of families of personnel who deployed to Timor-Leste with families that had not deployed to Timor-Leste, and found that the physical, mental and social health of the families of Defence personnel deployed to Timor-Leste was not significantly different to the comparable group that did not deploy to Timor-Leste. The partners who participated in the study were found to be generally in good physical and mental health, and the majority of children had normal emotional and behavioural health.[74]

5.74 Military service has nonetheless been found to have negative consequences for some families. A strong relationship was found in CMVH's TLFS between the Defence member's mental health and their partner's mental health. Further, if either parent had mental health issues then the children's health was likely to be affected also. The study found no evidence to suggest that the health of the families of Defence personnel varied with multiple deployments. However, partners themselves were more likely to negatively rate the impact of operational service with more

71 Mr Geoff Parker, *Submission 20*, pp. 1-2.

72 Centre for Military and Veterans' Health, *Submission 21*, p. 2; Department of Defence, *Submission 38*, p. 1.

73 Centre for Military and Veterans' Health, *Submission 21*, p. 9.

74 Centre for Military and Veterans' Health, *Submission 21*, pp. 6-7.

deployments, and were twice as likely to report their children had behavioural difficulties if the family had experienced two or more deployments.[75] Mr Tony Ralph, President of Brisbane Legacy, said:

> Supportive and supported families are an important element in treatment and recovery … [the] family role needs to be recognised, acknowledged and communicated. The recognition of the role of the partners and families in the treatment and rehabilitation of the wounded and injured veteran … is central to everything. There is a need to establish an appropriate means of acknowledging the partners and families in the treatment and rehabilitation of the wounded and injured.[76]

5.75 CMVH submitted that the findings of the TLFS show that, while all families are affected by deployment, most do not experience significant negative consequences. Those families that do suffer from the effects of operational service, however, show that there are many ways that support to military families can be strengthened and improved, and this will benefit all families.[77] Ms Julie Blackburn, the National Convenor of Defence Families of Australia (DFA), stressed that:

> Providing consideration for the support requirements of a member's next of kin in the treatment and subsequent planning for ongoing health, welfare and rehabilitation support arrangements is a necessary step to … prevent further harm and alleviate stress for both the member and their family.[78]

5.76 DFA also emphasised the importance of routine follow-up by suitable persons with members' families during convalescence, and that ongoing care and rehabilitation should be conducted in a location that best suits the member and their family, or that travel and accommodation is provided to next of kin as required.

5.77 Further, DFA submitted that when a member is sent home to their family to convalesce after a mental or physical injury, the family itself needs to be assessed. The care plan can then be adjusted appropriately dependent on their capabilities and situation, in collaboration with them. This ensures that that both the environment and the caregiver are suitably prepared to

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75 Centre for Military and Veterans' Health, *Submission 21*, pp. 7-8.

76 Mr Tony Ralph, President, Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 15.

77 Centre for Military and Veterans' Health, *Submission 21*, pp. 6-8.

78 Ms Julie Blackburn, National Convenor, Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 1.

assist the member recuperate. , and that case workers work with the whole family.[79]

5.78 Likewise, Legacy agreed that supportive and supported families are an important element to treatment and recovery.[80] General Cantwell made the point that a member's journey to recovery 'affects families, loved ones and mates'.[81]

5.79 Ms Blackburn advised the Committee that some families rely on VVCS for counselling services – feeling that it is independent of Defence or DVA – and are seeking care and attention elsewhere and look to alternative therapies.[82]

5.80 Both DFA and RSL Victoria submitted that it is vitally important that where possible, repatriated ADF members wounded or seriously injured on operations should be treated and rehabilitated in proximity to their families and that family connection is a vital aspect of an ADF member's mental rehabilitation.[83]

Psychological first aid

5.81 Dr Andrew Khoo, the Clinical Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that terms like PTS (post-trauma syndrome) or COSR (combat operational stress reaction) attempt to capture any psychological distress following operational trauma.

5.82 Dr Khoo submitted that there is an extensive amount of psychiatric literature dating back to the early 1900s which argues for on-site psychological intervention post-crisis. He advised that one of the oldest and best recognized of these approaches comes from Kardiner and Spiegel and is known as the PIE model. PIE stands for:

- Proximity – treat casualties close to the front or in the operational area;
- Immediacy – treat without delay; and
- Expectancy – with the expectation of a return to the front after rest/replenishment.[84]

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

80 Legacy Australia Council, *Submission 12*, p. 2

81 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 2.

82 Ms Julie Blackburn, National Convenor, Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 4.

83 Defence Families of Australia, *Submission 8*, p. 2; Returned and Services League of Australia, *Submission 11*, p. 4.

84 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 2.

5.83 Dr Khoo submitted that the US military has extended this model and adopted the use of BICEPS, an acronym which means:

- Brevity – interventions are within 1-3 days;
- Immediacy – treat without delay;
- Contact – chain of command and unit remains in touch with soldier;
- Expectancy – with the expectation of a return to the front after rest/replenishment;
- Proximity – treat casualties close to the front or in the operational area; and
- Simplicity – Brief, straight forward therapeutic methods used.[85]

5.84 A US military paper reports that COSRs can account for up to 50% of the battlefield casualties experienced on operations, and that the correct use of their procedures can return 95% of affected individuals to duty.[86] To that end, the ADF has embedded health staff and prepared fly in specialist teams to provide psychological and critical incident stress management support in operational areas.[87]

5.85 ACPMH submitted that embedding psychologists on deployment to provide interventions for psychological injury as quickly and proximally as possible has been a critically important innovation by Defence.[88] This was also applauded by Young Diggers.[89] Prof David Forbes, Director of the Australian Centre for Post-traumatic Mental Health (ACPMH), said:

> [Embedding psychologists] is an effective process. Philosophically, best practice is being able to provide those services as proximally as possible, to respond after incidents and then provide screening and support before deploying the members back to Australia.[90]

5.86 Austin Health's Psychological Trauma Recovery Service (PTRS) submitted that contemporary academic opinion would currently favour the use of psychological first aid (PFA) rather than debriefing, though not within two weeks of the traumatic event unless needed.[91] With respect to the military particularly, aspects of psych-education, information on the

85 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, pp. 2-3.

86 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 3.

87 Department of Defence, *Submission 17*, p. 6.

88 Australian Centre for Post-traumatic Mental Health, *Submission 23*, pp. 1-2.

89 Mr Mervyn Jarrett, President Young Diggers, *Committee Hansard*, 25 March 2013, p. 19.

90 Prof David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 11.

91 Psychological Trauma Recovery Service, *Submission 24*, p. 3.

various symptoms to monitor for and basic coping strategies, and appropriate avenues of referral both within the ADF and externally would be beneficial.[92]

5.87 Associate Professor Malcolm Hopwood, PTRS' Clinical Director, gave evidence that if an individual is identified through PFA as needing psychological help in theatre, it would not be appropriate for them to remain in that setting but should be returned to Australia.[93]

5.88 Dr Khoo went on to submit, however, that although founded on sound theoretical underpinnings, the effectiveness of these PFA models has never been proven and there is controversy surrounding utilisation of any form of mandatory intervention; that is, debriefing or critical incident stress debriefing (CISD), in that they have not been shown to prevent (and may even increase) subsequent PTSD.[94] He said:

> There is evidence in the literature that says that [debriefing] actually brought out … some PTSD that may not have been unmasked if people had been allowed to process it in their own time. So, for the last five to 10 years, the academic and clinical community, in treating PTSD, is being very careful in how we decide who we talk to and who we do not talk to after a major trauma. … The ADF is very aware of this critical incident stress debriefing debate.[95]

5.89 Dr Khoo went on to describe a better way of approaching PFA. He advocated having an approach where people are told:

> 'Everyone has been through this very psychologically distressing period. We just want you to know that there are certain symptoms that may appear that may tell us or may inform you that you are struggling, and these are what those symptoms are and this is where you go and get help.' That is now called psychological first-aid. That does not seem to increase rates of people having PTSD.[96]

92 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 3.

93 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 4.

94 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, p. 3.

95 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 13.

96 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 13.

Alternate and complimentary therapies

5.90 RADM Walker informed the Committee that Defence covers complementary therapies if there is a case put for it and there is an evidence-based clinical reason to do so. Defence, however, expect reports from the providers and evidence that the continued expenditure is of value to the patient:

> If someone needs a treatment, it is provided. The cost is not the factor that decides whether or not you have treatment; it is all about your clinical need and the evidence base for having that treatment.[97]

5.91 DVA's policy for entitlement to massage therapy does not, however, extend to veterans with PTSD on the basis it is not a musculoskeletal condition. Accredited, professional massage therapists attest to the fact that massage therapy has significant benefits in promoting relaxation and mental wellbeing and is complementary to other forms of treatment.[98] Other non-traditional treatments such as transcendental meditation, trauma release exercises[99], naturopathy and acupuncture,[100] yoga and Pilates,[101] art therapy and homeopathy have also reportedly had beneficial effects.[102]

5.92 Centori Pty Ltd submitted that adventure training programs improve the quality of life of Australia's wounded and the families of Australia's fallen. Centori highlighted the importance to a wounded or injured soldier's physical and mental recovery process of the 'individual success' aspect of participation in such activities.[103] Similarly, Dr Khoo reminded the Committee that there is very good evidence that, 'for all anxiety depressive disorders, physical exercise — as little as 20 minutes, four times a week — is almost as good as antidepressants'.[104]

5.93 Defence went on to reaffirm that they have not reduced the type or quantity of, or eligibility for, any health care services provided to ADF personnel unless it has been shown, based on evidence, that the service

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97 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, pp. 5, 8.

98 Name withheld, *Submission 16*, p. 8.

99 Trauma Release Australia, *Submission 35*, p. 3.

100 Mr Rod Martin, Director, Go2 Human Performance, *Committee Hansard*, 25 March 2013, p. 2.

101 Name withheld, Submission 40, p. 6.

102 Dr Jean Doherty, *Submission 26*, p. 1.

103 Centori, *Submission 28*, pp. 1–2.

104 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 12.

would not be an appropriate treatment. Any decision regarding the treatment to be provided to ADF personnel is based on the clinical need and the evidence base for having that treatment.[105]

Soldier Recovery Centres

5.94 Soldier Recovery Centres (SRC) provide tailored recovery training and education programs and support for wounded and injured personnel and their families. SRCs are an Army initiative, staffed with specialist Medical Corps personnel equipped with the skills and knowledge to facilitate a member's recovery following wounding, injury or illness. SRCs do this by coordinating with a range of service providers and agencies (including Joint Health Command, Defence Community Organisation, Transition Support Services, outside volunteer and ex-service organisations, and DVA).[106] 'Soldier I' commented that:

> Coming to the SRC has been really good. I have been able to have a constant, 100 per cent focus on myself and to de-stress. It also helps to be around people who are going through the same thing. It is nice to be able to focus your attention 100 per cent on yourself for a change.[107]

5.95 Although the SRC's primary goal is usually a return to work in the same role prior to entry into the SRC recovery program, this may not always be possible. Other outcomes could include a return to work in a different role in the Army or ADF, or a successful transition from Army.[108] The Committee heard from members attending the SRCs that:

> It is a place that you can come to get fixed up, put back on track and put on whatever avenue you want to go to.[109]
>
> They assist in dragging people out of depression and anguish and they work with them and get them to work with the physical[ly injured] members to assist them and vice versa. If you have ever sustained an injury, it is very easy to sit on the couch and go into a form of depression. … In my soldiering years I have never seen a level of care like this.[110]

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

106 Department of Defence, *Submission 17*, pp. 18-19.

107 Soldier I, *Committee Hansard*, 25 October 2012, p. 9.

108 Department of Defence, *Submission 17*, pp. 18-19.

109 Soldier B, *Committee Hansard*, 25 October 2012, p. 6.

110 Soldier F, *Committee Hansard*, 25 October 2012, p. 12.

5.96 Army SRCs were established in order to provide command, leadership and management of complex rehabilitation cases.[111] MAJGEN Gerard Fogarty AO, Head of People Capability, told the Committee:

> One of the principal lessons was that commanders, who ultimately are responsible for the care, support and wellbeing of their people, did not have adequate visibility of the number of their people who were on long-term rehabilitation plans. We need[ed] to do something about that straight away.[112]

5.97 MAJGEN Angus Campbell AM, Deputy Chief of Army, emphasised that:

> We will find a way to fund it, to sustain it and, as the evidence base demonstrates its value. Its location keeps it connected to the command structure and the support mechanisms of the habitual home bases.[113]

5.98 Soldiers in the SRCs believe that many injured personnel that remain with their units would do better in the Centre.[114] Comparing SRCs to the British experience, LTCOL Reade said:

> Most telling was that when their soldiers, sailors and airmen rehabilitate [in such a centre], they are in a service environment and they are supported by their peers.[115]

5.99 There has been good support for the SRCs. Mr Ralph strongly supported their formation because initiatives such as these embrace the family in the rehabilitation of the wounded member, and provide them a continuity of care.[116]

5.100 Young Diggers submitted that members given long term medical leave creates major issues when the member only sees his/her doctor once or twice per month and for the rest of the time is at home. In that scenario there is no unit discipline and the member has no connection to the military. This can then lead to problems like partnership breakdowns and

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111 AIRMSHL Mark Binskin AO, Acting Chief of the Defence Force, *Committee Hansard*, 9 October 2012, p. 1.

112 MAJGEN Gerard Fogarty AO, Head People Capability, *Committee Hansard*, 9 October 2012, p. 5.

113 MAJGEN Angus Campbell AM, Deputy Chief of Army, *Committee Hansard*, 9 October 2012, pp. 4 ,5 .

114 Soldier J, *Committee Hansard*, 26 March 2013, p. 12; Soldier K, *Committee Hansard*, 26 March 2013, p. 12. Soldier L, *Committee Hansard*, 26 March 2013, p. 12.

115 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 25.

116 Mr Tony Ralph, President, Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 17.

arrests for alcohol related incidents and violence. Young Diggers submitted that some members had even ended up in prison.[117]

5.101 SRCs are now operating in Townsville, Darwin, Brisbane and Holsworthy in Sydney.[118]

Committee comment

5.102 The Committee commends the Army on the establishment of SRCs and believes that they should overcome the bulk of these issues raised by Young Diggers, and believes they will remedy the experiences of some members who in the past felt that they were:

> Expected to simply wait with the other injured members and basically do nothing ... [or do] 'arts and crafts'.[119]

5.103 The Committee commends General Cantwell and organisations such as Soldier On and Young Diggers who are leading in the fight to de-stigmatise PTSD and other mental health disorders in the community. This will hopefully assist more wounded members to come forward to seek support and treatment. The Committee also agrees with General Cantwell in that senior enlisted leadership is also important in overcoming the stigma towards mental disease within the ranks.

5.104 The Committee applauds Defence's support of complimentary therapies and encourages DVA to adopt a policy in line with that of Defence with respect to complimentary therapy cost coverage.

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.

5.105 The Committee acknowledges that ADF members dealing with PTSD have access to the full range of mental health services and rehabilitation services. The Committee recognises that Defence has made significant

117 Young Diggers, *Submission 22*, p. 1.

118 Department of Defence, *Submission 17*, pp. 18-19.

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

improvements in these services, and that improvements will continue to be made. The Committee also acknowledges that Defence will see what further education and support might be offered to help ensure all members are aware of the risks associated with mental health issues, including PTSD, and know how to address this risk.[120]

5.106 The Committee is, however, concerned at the ongoing reports of issues in the treatment of mental health disorders within the ADF and broader veteran community, particularly in the wake of the recommendations of the 2009 *Review of Mental Health Care in the ADF and Transition through Discharge* and the *2010 ADF Mental Health Prevalence and Wellbeing Study* and resultant mental health reform program.

Recommendation 8

The Committee recommends that the Department of Defence publish periodic detailed written assessments on:

- **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;***
- **The Australian Defence Force mental health reform program; and**
- **What additional enhancements have been made to current programs, as indicated in the Defence White Paper.**

5.107 The Committee is very concerned at the issues raised in *The Health and Wellbeing of Female Vietnam and Contemporary Veterans* report regarding female veterans' mental health. The Committee finds none of the barriers or gaps identified in the report as being inconsistent with the broader issues identified in the course of this Inquiry. The Committee therefore fully endorses Dr Crompvoets' recommendations, most of which are reflected in the recommendations of this Inquiry.

5.108 The Committee is also concerned at the issues relating to the psychological support of the families of serving and ex-serving veterans. The Committee therefore recommends that an assessment of that support be undertaken with the objective of addressing mental health issues of

120 Department of Defence, *Defence White Paper 2013*, p. 105.

partners and families such have been highlighted in the Inquiry and any others subsequently identified.

5.109 The Committee particularly recognises and acknowledges the stress that service-related psychological issues can have on marriages.

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.

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.

5.110 Finally, the Committee feels that some form of psychological first aid may provide an appropriate vehicle for overcoming some of the trauma-related mental health issues and is worthy of consideration for inclusion in ADF standard operating procedures.

Recommendation 10

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