R O B E R T J S H O R T R I D G E

22 June, 2015

The Chairman
Senate Inquiry on Mental Health of ADF Personnel
Foreign Affairs, Defence and Trade Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Sir,

Please find attached my submission to the Senate Inquiry on the Mental Health of ADF personnel.

R.J.Shortridge

Enclosure 1. Submission to the Senate Inquiry on Mental Health of ADF Serving Personnel by Robert J Shortridge

SUBMISSION TO THE SENATE INQUIRY
ON
MENTAL HEALTH OF ADF SERVING PERSONNEL
BY
ROBERT J SHORTRIDGE

Executive Summary

- There are a number of meanings of the term 'veteran' in this environment.
- Data shows only 20% of personnel leave the ADF as DVA clients but the transition from the ADF to DVA is often wanting.
- Data shows 80% of personnel leave the ADF without being a DVA client but many of them may need DVA help in the future.
- The ADF does not do a good job briefing ADF personnel on what DVA services and support may be available to them post the ADF.
- No one should be discharged from the ADF without all DVA/COMSUPER issues being resolved, especially those being discharged on medical grounds.
- Maintaining records of those ex service personnel once they have left the ADF will be very difficult as there is no compulsion for them to identify themselves as ex service personnel or veterans.
- There is a significant amount of high quality DVA support available but knowledge of the support and how to access it in the wider ex-service community is sparse.
- Getting information out to those who have left the ADF is a challenge.
- DVA is hampered by antiquated IT systems that force a reliance on hard copy files that have to be transferred form one responsible area to another, interstate.
- Legislation under which DVA operates can be changed whether through the court process or by lobbying parliament for change but this action must be initiated by aggrieved parties, not DVA.
- The DVA requirement for reports from medical specialists is onerous for the specialist and not high on their list of priorities.

Terms of Reference

The mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment, with particular reference to:

a. the extent and significance of mental ill-health and post-traumatic stress disorder (PTSD) among returned service personnel;
b. identification and disclosure policies of the ADF in relation to mental ill-health and PTSD;
c. recordkeeping for mental ill-health and PTSD, including hospitalisations and deaths;
d. **mental health evaluation and counselling services available to returned service personnel**;
e. the adequacy of mental health support services, including housing support services, provided by the Department of Veterans' Affairs (DVA);

f. the support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD;
g. the growing number of returned service personnel experiencing homelessness due to mental ill-health, PTSD and other issues related to their service;
h. the effectiveness of the Memorandum of Understanding between the ADF and DVA for the Cooperative Delivery of Care;
i. the effectiveness of training and education offerings to returned service personnel upon their discharge from the ADF; and
j. any other related matters.

By way of introduction.

I served in the Royal Australian Air Force (RAAF) for 36 years and deployed to East Timor, Kyrgyzstan and Baghdad. I retired in 2006. I have been diagnosed with PTSD and I am currently on a small DVA pension.

I am now President of the Defence Force Welfare Association (DFWA) Qld Branch Inc, a member of the Queensland Forum of Ex Service Organisations (QFE), DVA's Queensland Consultation Forum (QCF) and the Queensland Government Veteran's Advisory Council (QVAC).

I am also a life subscriber of the RSL, the Welfare Officer of the Combat Support Association and a member of Young Diggers.

This submission focusses on items c, d, e, f, and i of the terms of reference.

What is a Veteran?

The first thing is the definition of Veteran. The dictionary definitions are:

- a person who has had long service or experience in an occupation, office, or the like: or
- a person who has served in a military force, especially one who has fought in a war

When it comes to DVA however, and its application of the two applicable Acts i.e. the VEA 1986 and the MRCA 2004 the term 'veteran' is not so precise. It is this difference that is the basis of much of the confusion many have in dealing with DVA. While not specifically related to this submission the committee should note that:

a. VEA 1986 defines a 'veteran' as a person who is, because of section 7 of the Act taken to have rendered eligible war service. The Act then proceeds to apply several confusing caveats.

b. MRCA Act 2004 defines a 'veteran' as someone who has been involved in 'warlike service' of a kind determined in writing by the Defence Minister for the purposes of this Act. Recent history tells us that such determinations have come years after the warlike service.

Only 20% of members leaving the ADF do so as DVA clients.

Of the 20% that leave the ADF as DVA clients all their DVA/COMSUPER (ADF super schemes have a death and disability component) issues must be resolved before they discharge and this is especially critical for people who are leaving on medical grounds. The intent should be that transfer of responsibilities for care and support from the ADF to DVA should be seamless. What is being seen in by the Ex-Service Organisations (ESO) is that this does not appear to be the case as people are being discharged and being left to fend for themselves with DVA and COMSUPER. Such individuals do not necessarily go to an ESO for assistance, if in fact they are aware of the assistance that could be provided. When they find out about it, pension officers and advocates with the ESO will do what they can but this should not be necessary if the ADF do not discharge these people until all the DVA/COMSUPER issues are resolved.

The other consideration is that once a person discharges they are no longer ADF and they may not want to identify themselves as an ex serving member of the ADF. Identifying the medical issues associated with these people may be relatively easy if they are DVA clients but this would only be for accepted conditions, or all conditions if one has a Gold Card. Recording homelessness and suicide rates for these people would be virtually impossible as there is no compulsion for them to identify themselves as veterans and while DVA would know of their death (so allowances could cease) they would not necessarily know the cause.

The 80% of personnel who leave the ADF without being a DVA client.

Former members of the ADF create an interesting challenge. Often issues that are service related can occur sometime after discharge, and the very real issue is how do these people seek help? How do they even know help is available? In my own personal situation I was fine when I was working and my brain was busy and occupied but when I retired and had time to think, my world changed, and not for the better. Fortunately, I knew how to access help.

The ADF pay lip service to support available post ADF. Personally, I served for 36 years and only started to be interested shortly before I retired. In 2012 I did a year of reserve work and worked with a unit at Amberley that planned for and supported deployed operations. I did a straw poll and asked 10 people if they knew what Veterans and Veterans Families Counselling Service (VVCS) was and only one knew yet, this is an excellent DVA sponsored counselling service available to current and ex ADF personnel and their families through DVA. In my role as President of DFWA Qld Br Inc I have had a 75 year old Vietnam Veteran who did not know he was entitled to a Gold Card at age 70. This meant for five years he was paying for his medical care when he didn't need to.

The ADF will claim that they advise people of post ADF care at pre and post deployment briefings, transition seminars and during the discharge process but this is too little too late. I would argue absorbing information on post ADF support would not be a priority at these times given other issues that would focus a member's attention such as; preparations for deployment, desire to get home after a deployment, removals, job applications, children's schooling and the spouses employment if moving to a new location on discharge.

The other issue is that there is no compulsion on the 80% to identify themselves as former members of the ADF or veterans once discharged therefore recording statistics (suicide, homelessness, hospitalisations and death) on this cohort would be almost impossible.

The ADF has a huge role to play:

To be fair, one has to look at the whole compensation, treatment and rehabilitation chain, not just the DVA part of it.

- The only time there is positive control over the personnel is while they still serving and therefore the ADF needs to ensure all personnel, including their families, are made aware of the various support opportunities that are available to them post the ADF, on a regular basis, as they progress through their ADF career.
- Families are absolutely critical in the care continuum as often the spouse is the first one to recognise there are issues before they become critical. The ADF pays lip service to including families in any briefings on post ADF support.
- Personnel also need to know the necessity to make sure that any issues are recorded so, if and when a claim is submitted, it facilitates determination that a matter is service related.
- If a person is to be discharged from the ADF for medical reasons, the ADF should not discharge a person until all the DVA/COMSUPER (the ADF super schemes have death and disability cover) issues have been settled. Recent reports in the media experience at the ESOs indicates this may not be the case. It appears that the ADF will discharge an individual on the premise they then become DVA's responsibility.

Currently all units conduct annual inductions as there is a mandated annual requirement to ensure personnel are briefed on WHS, EEO and fraud and ethics as well as being advised of the Commander's intent for the year. A briefing on DVA services post ADF at this time would be appropriate. Younger people consider themselves fire proof but if they get a briefing annually then it may stick that they may be entitled to help post ADF and who is available to assist them should it be necessary to seek support.

The member needs to be an informed consumer.

- Sometimes this is difficult given the complexity of the claims process which is why there are pensions and welfare officers and advocates in the ESO. While all these people are DVA trained through the TIP program the standards and knowledge vary significantly. If a claim is not done properly, there is potential for significant delays or even rejection.
- The system, while serving in the ADF, is a push system in that if one is seen to be going off the rails friends, workmates or the command chain will push a member to get help. Once a person is outside the ADF it is pull. One has to ask for help but the trick is knowing who to ask and how to get the help.
- The individuals themselves need to ensure that all issues are recorded on medical and other documents. The problem is twofold:

    - for some issues, members are reluctant to be treated by ADF medical staff due to perceptions (real or otherwise) that it will affect their careers. This can make it very difficult to prove an issue is service related when a future claim is submitted.
    - ADF medical records are sometimes found wanting.
- Due process needs to be followed. An example is as follows:
    - DVA will treat, as distinct from compensate, for PTSD, cancers (and a number of other conditions) under non liability health care and the only qualifying criteria was that of having been a former member of the ADF for more than two years from 1972. A former member went to his GP who said he had PTSD and referred him to Greenslopes Hospital who refused to treat him and told him to see the ESO advocate that worked from the hospital. The process is that he should have, with his GP referral, seen a pension's officer or advocate, put in a claim on DVA, get a white card and then he would get treatment (this action can happen quite quickly). This person was blaming DVA when in fact it was his problem as he did not know the process, or try to find out.
- There is sometimes a degree of learned helplessness which can be exacerbated if there are mental health issues and there seems to be a reluctance to complain and/or push the issue up the chain using personal networks or an ESO. I have worked with DVA at the higher levels and have been impressed by the way they react to legitimate grievances that are brought to their attention.

DVA services are of a high standard

Overall the belief is that DVA do a good job supporting their clientele. They are a bureaucracy and that means processes can be a little slow and they are not supported by a computer system that will allow them to do their work digitally. They still rely on hard copy files which have to be transferred from office to office and state to state depending on what part of a person's claim is being processed, which can result in delays.

There is also a perception that the DVA requirements of medical specialists are overly onerous. It is not reasonable to expect a specialist to spend hours filling in reports for DVA. A review of the requirement for these reports or some way of reducing specialist's workload to support DVA needs should be examined to reduce claims processing times.

DVA have some brilliant programs especially VVCS that supports veterans and families for mental health evaluation and counselling services as well as running programs to assist with mental health issues but, the problem is how to get the message out to the ex-service community, especially the families.

DVA have embraced social media and there are some good messages in this medium but again the issue for those in need is knowing where to look. I share any DVA issues I see on social media to the ESOs that I am involved with in an attempt to get the message out.

The challenge is how DVA, or Defence, get the message out to ex serving personnel once they have discharged to ensure they can access support networks if and when needed.

The ‘cyber warriors’, the press and sometimes politicians often focus on the lack of service and support provided by DVA. Detailed examination of the specific cases often reveal that, while there may be issues, and a person may feel disenfranchised, the causes of the problems are often outside the control of DVA.

Legislation.

DVAs operations are bound by legislation. There are three acts Veterans Entitlement Act – 1986 (VEA), Safety Rehabilitation and Compensation Act – 1988 (SRCA) and the Military Rehabilitation and Compensation Act - 2004 (MRCA). Some of the legislation is wanting especially where there are offsets between MRCA payments and COMSUPER payments but one cannot blame DVA for those, even though they may be perceived to be unfair. There is also a perception that some acts are more beneficial than others and that is seen in some circles to be discriminatory. There is a mechanism for changing legislation, either through the courts or by getting parliament to amend it. Aggrieved parties should consider taking this action to resolve issues, not blame DVA.

Governance

As a tax payer I expect DVA to do due diligence and that means that they should not just accept everything they are told. Unfortunately, in the world of medicine things are rarely black and white hence there may be differing opinions between medical professionals but that is why there is a VRB and AAT to formally review decisions.

In summary

There are a number of meanings of the term ‘veteran’ in this environment.

Data shows only 20% of personnel leave the ADF as DVA clients but the transition from the ADF to DVA is often wanting.

Data shows 80% of personnel leave the ADF without being a DVA client but many of them may need DVA help in the future.

The ADF does not do a good job briefing ADF personnel on what DVA services and support may be available to them post the ADF.

No one should be discharged from the ADF without all DVA/COMSUPER issues being resolved, especially those being discharged on medical grounds.

Maintaining records of those ex service personnel once they have left the ADF will be very difficult as there is no compulsion for them to identify themselves as ex service personnel or veterans.

There is a significant amount of high quality DVA support available but knowledge of the support and how to access it in the wider ex-service community is sparse.

Getting information out to those who have left the ADF is a challenge.

DVA is hampered by antiquated IT systems that force a reliance on hard copy files that have to be transferred form one responsible area to another, interstate.

Legislation under which DVA operates can be changed whether through the court process or by lobbying parliament for change but this action must be initiated by aggrieved parties, not DVA.

The DVA requirement for reports from medical specialists is onerous for the specialist and not high on their list of priorities.

It is recommended that:

The ADF develop a program to mandate an annual briefing for personnel and their families on DVA services that may be available post ADF as well as mandating a DVA briefing be made at pre and post deployment briefs, transition seminars and during the actual discharge process.

The ADF must not discharge a person until all DVA/COMSUPER actions are resolved, this is particularly critical for medical discharges (which includes PTSD).

DVA should get supplemental funding from the Government to implement an urgent, priority upgrades to computer systems that will allow a vast majority of their work to be done in the digital environment.

DVA to review the requirement for medical specialists in an endeavour to reduce the workload on them in order to get timely reports to enable finalisation of claims.

Robert J Shortridge