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The Parliament of the Commonwealth of Australia

# Care of ADF Personnel Wounded and Injured on Operations

**Inquiry of the Defence Sub-Committee**

Joint Standing Committee on Foreign Affairs, Defence and Trade

June 2013  
Canberra

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## Foreword

Over the last 15 years, Australia's Defence Forces have been almost continuously involved in operations from Africa to the Solomon Islands, and everywhere in between. Unfortunately not all those that have deployed on operations have returned, and some that have returned, have done so with wounds and scars, not all of which are necessarily visible.

The Defence Sub-Committee welcomed the opportunity presented by this Inquiry to consider the treatment of personnel wounded and injured on operations, their repatriation to Australia, on-going care and return to work, or transition out of the Defence Force.

In our inquiry, we have examined the concerns of wounded and injured members themselves, identified opportunities to improve governmental services provided to them, and looked at some of the perceived or actual barriers preventing full access to support services. We delved deeply into the concerns related to post traumatic stress disorder (PTSD) and other mental health issues, and explored the importance of the involvement of, and support to, families in the recovery process of the wounded and injured.

With the recent increased awareness of the effects of depression, anxiety disorders, substance abuse and indeed PTSD, and issues surrounding suicide rates amongst current and former servicemen and women, the inquiry was particularly timely. Indeed, as can be seen from the evidence we received, there is a broad community concern at the effect that service, operational or otherwise, is having on members and their families.

Part of Australia's national identity is formed around the courage and sacrifice of our uniformed services, from the beaches of Gallipoli to the mountains and deserts of Afghanistan. The modern veteran has, in common with the shell-shocked or maimed Digger of World War I or the Vietnam veteran, the right to the best support and services that the country can provide. Since the First Gulf War, over 45,000 Australians have seen operational service and, even with the prospect of a

reduced tempo of operations, the support of this new cohort of veterans must develop on the lessons of the past and continue to be improved.

The Committee considers that, for the most part, the care provided to Australia's wounded and injured is world class, particularly in the immediate aftermath of a battlefield incident. The Departments of Defence and Veterans' Affairs have honoured their responsibilities to support the recovery and rehabilitation of these individuals and their families and, through various programs, continue to improve veteran support processes and coordination.


Unfortunately, some veterans still 'fall through the cracks'. This has to end.

We have developed a series of recommendations to ensure a comprehensive rehabilitation process for the physically wounded; that all forms of mental health issues in our service, ex-service and veteran communities are fully understood and supported; that the importance of families is fully recognised; and that communication and coordination between all agencies involved in the support of our veterans, government and non-government, is optimised.

In the course of the Inquiry, the Committee had the opportunity to travel to a number of cities and meet individuals and organisations supporting Australia's veterans - the Committee thanks them, and everyone else so involved, for their contribution. Importantly, the Committee were honoured to meet representatives of those who have put themselves in harm's way in defence of our nation's values, and who are carrying scars as a result - the Committee salutes each one.


I conclude by thanking members of the Defence Sub-Committee for their contribution to the inquiry. We were able to work in a true spirit of bi-partisanship, which is what the Parliamentary Committees do best. Finally, as always, I thank our servicemen and women for their dedicated contribution to the security of our nation.

Senator Mark Furner  
Chair



## Membership of the Committee

<b>Chair</b>	Senator Michael Forshaw (to 30/06/11)	
	Mr Michael Danby MP (from 1/07/11 to 15/05/13)	
	Hon Joel Fitzgibbon MP (from 15/05/13)	
<b>Deputy Chair</b>	Mrs Joanna Gash MP	
<b>Members</b>	Senator Mark Bishop	Hon Anthony Byrne MP
	Senator the Hon John Faulkner (from 30/09/10 to 14/02/11)	(to 14/03/12; from 19/09/12)
	Senator David Fawcett (from 1/07/11)	Mr Nick Champion MP
	Senator the Hon Alan Ferguson (to 30/06/11)	Hon Laurie Ferguson MP
	Senator Mark Furner	Mr Steve Georganas MP (to 24/03/11)
	Senator Sarah Hanson-Young	Mr Steve Gibbons MP (to 7/02/12)
	Senator the Hon David Johnston	Hon Alan Griffin MP
	Senator Scott Ludlam	Hon Harry Jenkins MP (from 7/02/12)
	Senator the Hon Ian Macdonald	Dr Dennis Jensen MP
	Senator Anne McEwen (from 1/07/11)	Hon Richard Marles MP (from 14/05/13)
	Senator Claire Moore	Hon Robert McClelland MP (from 14/03/12 to 19/09/12)
	Senator Kerry O'Brien (from 14/02/11 to 30/06/11)	Mrs Sophie Mirabella MP
	Senator Stephen Parry (from 1/07/11)	Hon John Murphy MP
	Senator Marise Payne	Mr Ken O'Dowd MP (from 25/10/10)
	Senator the Hon Ursula Stephens (from 1/07/11)	Ms Melissa Parke MP (to 5/02/13)
	Senator Russell Trood (to 30/06/11)	Mr Stuart Robert MP
		Hon Philip Ruddock MP
	Hon Dick Adams MP (from 24/03/11)	Ms Janelle Saffin MP
	Hon Julie Bishop MP	Hon Bruce Scott MP
	Ms Gai Brodtmann MP	Hon Peter Slipper MP (from 1/11/12)
		Hon Dr Sharman Stone MP (from 25/10/10)
		Ms Maria Vamvakinou MP



# Membership of the Defence Sub-Committee

Chair            Senator Mark Furner

Deputy Chair   Dr Dennis Jensen MP

Members        Senator Mark Bishop  
                    Senator David Fawcett (from 1/07/11)  
                    Senator the Hon David Johnston  
                    Senator the Hon Ian Macdonald  
                    Senator Stephen Parry  
                    Senator Marise Payne  
  
                    Hon Dick Adams MP (from 24/03/11)  
                    Ms Gai Brodtmann MP  
                    Mr Nick Champion MP  
                    Hon Michael Danby MP (*ex officio*) (to  
                    14/05/13)

Hon Joel Fitzgibbon MP (*ex officio*)  
Mrs Joanna Gash MP (*ex officio*)  
Hon Alan Griffin MP  
Mr Harry Jenkins MP (from 7/02/12)  
Mrs Sophie Mirabella MP  
Mr Ken O'Dowd MP (from 25/10/10)  
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## Terms of reference

The Joint Standing Committee on Foreign Affairs, Defence and Trade shall examine and report on the care of ADF personnel wounded and injured on operations, with particular reference to:

- (a) treatment of wounded and injured ADF personnel while in operational areas;
- (b) repatriation arrangements for wounded and injured personnel from operational areas to Australia;
- (c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements;
- (d) return to work arrangements and management for personnel who can return to ADF service; and
- (e) management of personnel who cannot return to ADF service including:
  - (i) the medically unfit for further service process;
  - (ii) transition from ADF managed health care and support to Department of Veterans' Affairs managed health care and support; and
  - (iii) ongoing health care and support post transition from the ADF.



## List of abbreviations

A&D	Alcohol and Drug
A-SWIIP	Army - Support to Wounded, Injured and Ill Program
AAT	Administrative Appeals Tribunal
ACPMH	Australian Centre for Post-traumatic Mental Health
ADF	Australian Defence Force
AECC	Aeromedical Evacuation Control Centre
AFOF	Australian Forces Overseas Fund
AIRMSHL	Air Marshal
AME	Aeromedical evacuation
ANAO	Australian National Audit Office
ANU	Australian National University
APS	Australian Public Service
ASCN	Australasian Services Care Network
CAT	Combat-Application-Tourniquet
CBT	Cognitive behaviour therapy
CDF	Chief of the Defence Force
CDRE	Commodore

CISD	Critical Incident Stress Debriefing
COSR	Combat Operational Stress Reaction
CMVH	Centre for Military and Veterans' Health
CTFS	Continuous Full Time Service
DCO	Defence Community Organisation
DFA	Defence Families of Australia
DVA	Department of Veterans' Affairs
Defence	Department of Defence
DPSM	Defence Personnel Systems Modernisation
DSG	Defence Support Group
eHealth record	Personally Controlled Electronic Health Record
FTE	Full Time Equivalent
GARP	Guide to the Assessment of Rates of Veterans' Pensions
HQJOC	Headquarters Joint Operations Command
ID	Identification
IED	Improvised Explosive Device
ISAF	International Security Assistance Force
ITAA 1936	<i>Income Tax Assessment Act 1936</i>
KPI	Key Performance Indicators
Legacy	Legacy Australia Council
LTCOL	Lieutenant Colonel
MAJGEN	Major General
MEAO	Middle East Area of Operations
MEC	Medical employment classification



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MECRB	Medical Employment Classification Review Board
MHCSU	Mental Health Clinical Service Unit
MHS	Medibank Health Solutions
MMU	Multinational Medical Unit
MOU	Memorandum of Understanding
MRCA	<i>Military Rehabilitation and Compensation Act 2004</i>
NATO	North Atlantic Treaty Organization
NOK	Next of Kin
NOTICAS	Notification of casualty
PACMAN	Pay and Conditions Manual
POPS	Post Operation Psychological Screen
RAAF	Royal Australian Air Force
RAP	Regimental Aid Post
RMA	Repatriation Medical Authority
RSL	Returned and Services League of Australia
RSL WA	Returned and Services League of Australia WA Branch
RSO&I	Reception Staging Onward Movement and Integration
PFA	Psychological First Aid
PTS	Post Trauma Syndrome
PTSD	Post-Traumatic Stress Disorder
PTRS	Austin Health's Psychological Trauma Recovery Service
RADM	Rear Admiral
RtAPS	Return to Australia Psychological Screen
SF	Special Forces

SGT	Sergeant
SMART	Stress Management and Resilience Training
SRC	Soldier Recovery Centre
SRCA	<i>Safety, Rehabilitation and Compensation Act 1988</i>
SWIIP	Support for Wounded, Injured or Ill Program
TLFS	Timor-Leste Family Study
TPH	Toowong Private Hospital
TRE	Trauma release exercises
TRiM	Trauma risk management
TRMHDs	Trauma-related Mental Health Disorders
US	United States
VAC	Veterans' Advisory Council
VEA	<i>Veterans' Entitlements Act 1986</i>
VHAC	Veteran' Health Advisory Council
VRB	Veterans' Review Board
VVAA	Vietnam Veterans' Association of Australia
VVCS	Veterans and Veterans' Families Counselling Service
VVFA	Vietnam Veterans' Federation of Australia
VVPPAA	Vietnam Veterans' Peacekeepers and Peacemakers Association of Australia



## List of recommendations

### 3 Aeromedical Evacuation

#### Recommendation 1

The Committee recommends that the Department of Defence continue to make regular contributions to Fisher House as an ongoing measure of Australia's appreciation for the service provided to our wounded soldiers, until such time that Australian soldiers are no longer deployed to Afghanistan.

#### Recommendation 2

The Committee recommends that the Department of Defence and the Australian Taxation Office ensure that Australian Defence Force personnel medically evacuated to Australia retain tax free status for the notional length of their operational deployment, or the actual length of the deployment of their unit, per subsection 23AG(1) of the *Income Tax Assessment Act 1936*.

#### Recommendation 3

The Committee recommends that the Department of Defence ensure that Australian Defence Force personnel medically evacuated to Australia continue to accrue War Service Leave and allowances for the notional length of their operational deployment, or the actual length of the deployment of their unit.

#### Recommendation 4

The Committee recommends that the Department of Defence and the Australian Taxation Office assist Australian Defence Force personnel previously medically evacuated, and to whom Recommendations Two and Three would have applied, to make successful retrospective claims for reimbursement.

## 4 A Badge of Honour

### Recommendation 5

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

### Recommendation 6

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

## 5 Mental Health Concerns

### 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.

### 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.

### 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.

#### 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.

## 6 Falling Through the Cracks

#### Recommendation 11

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

#### Recommendation 12

The Committee recommends that the Government conduct a cost-benefit study of a comprehensive uncontested veteran healthcare liability model and publish the results.

#### Recommendation 13

The Committee recommends that the departments of Defence and Veterans' Affairs coordinate to clarify the Australian Defence Force/Veteran service delivery models to reduce the complexity, overlaps and gaps in service identified in this report.

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

#### Recommendation 14

The Committee recommends that a wounded or injured soldier who wishes to remain in the Defence environment and applies for a position within the Australian Public Service, for which they have the required skills and competencies, be selected preferentially.

The Committee further recommends that the Government encourage private sector providers to take a similar approach to the preferential employment of wounded and injured soldiers.

#### Recommendation 15

The Committee recommends that the departments of Defence and Veterans' Affairs expedite the rectification of information technology connectivity issues.

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

#### Recommendation 16

The Committee recommends that:

- as an immediate priority, the national healthcare community include a military/ex-military checkbox as a standard feature on all medical forms; and
- the Government commission a longitudinal tracking system to identify the engagement of military/ex-military personnel with the healthcare system.

## 7 Return from Operations

#### Recommendation 17

The Committee recommends that the departments of Defence and Veterans' Affairs sponsor a program of research examining the development of post-deployment syndromes in the current veteran cohort, be it relating to mild traumatic brain injury or some other cause.

#### Recommendation 18

The Committee recommends that the Department of Defence review the adequacy and rigour of pre- and post- deployment health checks.

### Recommendation 19

The Committee recommends that the Department of Defence provide all troops returning from operations, including non-warlike operations, targeted psychological first aid and post-deployment psycho-education which should include:

- Education on human responses to trauma;
- Identification of basic signs and symptoms of mental health conditions; and
- Advice on assistance options.

### Recommendation 20

The Committee recommends that the departments of Defence and Veterans' Affairs conduct an assessment of suicide rates in the military/ex-military community as a priority.

### Recommendation 21

The Committee recommends that the departments of Defence and Veterans' Affairs establish strategic research priorities to address suicide attributable to defence service.

### Recommendation 22

The Committee recommends that the Department of Defence establish formal, Defence-wide pre- and post-deployment training for service families, and a periodic contact program for the families of deployed members.

## 8 Veterans Affairs

### Recommendation 23

The Committee recommends that the Department of Veterans' Affairs:

- Review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted;
- Periodically publish reports measuring success in adhering to their client service model;

- Periodically publish claim processing times; and
- Periodically publish claim success rates.

#### Recommendation 24

The Committee recommends that the Department of Veterans' Affairs conduct a study, and publish the results, reflecting the issues raised in evidence during the Inquiry, concerning:

- Developing a standardised approach to recruitment, including the preferential recruitment of ex-service members as Case Managers; and
- Training and ongoing evaluation of Case Managers.

## 9 Veterans' Support Structures

#### Recommendation 25

The Committee recommends that the Government commission an independent assessment of the need for, and establish if warranted, an appropriate national/state-based veterans' organisation coordination body.



# Service and Sacrifice

## Introduction

- 1.1 On 15 June 2012 the Minister for Defence Science and Personnel, the Hon Warren Snowdon MP, asked the Committee to inquire into and report on the Care of Australian Defence Force Personnel Wounded and Injured on Operations.

## Context

- 1.2 As the Department of Defence (Defence) submitted to the Committee, service in the Australian Defence Force (ADF) is demanding and unique. Defence members may be required to work long hours, shift work and irregular hours under harsh environmental conditions. As well as facing the possibility of service in hostile areas, Defence members participate in other forms of operational activities where a degree of personal risk still exists.<sup>1</sup>
- 1.3 The ADF has now been continually involved in Operations for over a decade. The 2011-12 Defence Annual Report lists 17 separate Operations that the ADF conducted in that period.<sup>2</sup> Since 1999, ADF personnel have undertaken some 134,000 individual deployments, and no doubt many have deployed on numerous occasions.<sup>3</sup>
- 1.4 While many of these Operations are carried out in benign environments, a number are not. Consequently, there have been a number of ADF

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1 Department of Defence, *Submission 17*, p. 2.

2 Department of Defence, *2011-2012 Defence Annual Report*, pp. 116-122.

3 Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force (CDF), *Committee Hansard*, 9 October 2012, p. 1.

personnel killed or wounded on Operations in recent times. The return to Australia and the support to the families of those personnel tragically killed on Operations is highly publicised, however, the management and support of those personnel who are wounded is not so widely discussed.

- 1.5 The Minister for Defence Science and Personnel wanted the Committee to assure itself that appropriate care and support is being given to ADF personnel wounded on Operations in support of Australian objectives.
- 1.6 Since Operation SLIPPER (the ADF's contribution to the war in Afghanistan) commenced, 251 ADF members have been wounded in action in Afghanistan (see also Appendix D). The types of injuries sustained can be broadly categorised as:<sup>4</sup>
- Amputations;
  - Fractures;
  - Gunshot wounds;
  - Hearing loss;
  - Lacerations/contusions;
  - Concussion/traumatic brain injury;
  - Penetrating fragments; and
  - Multiple severe injuries.
- 1.7 This does not include those returning from Operations suffering psychological injuries. Defence advised that acute psychological injury has not previously been included in the ADF definition of battle casualties. However there are circumstances where acute psychological conditions arise as a result of direct contact with the enemy or as a result of direct exposure to the consequences of enemy action. Criteria have been developed to provide a framework to classify acute psychological casualties as battle casualties. The casualty must have a clear diagnosis of acute psychological illness, be unable to perform their duties on operations, and require medical return to Australia for their condition within one month of exposure.
- 1.8 Members who develop mental health conditions on deployment but not as a result of direct contact with the enemy or subsequent consequences of the contact or post-deployment are not classified as battle casualties.<sup>5</sup>
- 1.9 The Department of Veterans' Affairs (DVA) submitted that they have a strong and proud history of supporting those men and women who have offered service to our nation and the families who have made sacrifices to
- 

4 Department of Defence, *Submission 17*, p. 11.

5 Department of Defence, *Submission 17*, p. 9.

support them. Over the course of its 94 years of operation, DVA claims to have developed considerable knowledge and skills in understanding the risks and effects arising from the unique and demanding nature of military service.

- 1.10 DVA is currently transforming its service delivery models to meet the emerging needs of the contemporary cohort of veterans and their families. This cohort is part of a broader base of clients for the Department, from veterans and war widows aged over one hundred years old, to children as young as one year old. DVA has an ongoing role in the care and support for this wide range of clients.<sup>6</sup>

### 2013 Wounded in Action incidents in Afghanistan

- 1.11 As at 22 April 2013, six ADF personnel have suffered wounds as a result of battle in 2013; two were wounded in an improvised explosive device detonation, three were wounded in small arms fire incidents and one was wounded as a consequence of the conduct of operations.
- 1.12 As for the types of injuries sustained, one has suffered a gunshot wound, four have suffered fragmentation wounds, and one suffered other injuries.<sup>7</sup>

### Injuries sustained

- 1.13 Committee members were deeply moved by the stories of individuals who contributed to the inquiry who have suffered a variety of injuries, wounds and poor health as a result of their operational service. These included the effects of an improvised explosive device (IED) causing a shattered femur, hearing loss and loss of bowel control;<sup>8</sup> IEDs causing crushed vertebrae<sup>9</sup> and other spinal injuries;<sup>10</sup> IEDs causing shattered limbs and traumatic brain injury;<sup>11</sup> IEDs causing shrapnel injury;<sup>12</sup> multiple gunshot wounds;<sup>13</sup> badly twisted ankles and subsequent compounded injuries;<sup>14</sup> falls on patrol causing back and shoulder

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6 Department of Veterans' Affairs', *Submission 18*, p. 3.

7 Department of Defence, viewed 30 May 2013, <[www.defence.gov.au/op/afghanistan/info/personnel.htm](http://www.defence.gov.au/op/afghanistan/info/personnel.htm)>.

8 Name withheld, *Submission 2*, p. 1.

9 Soldier A, *Committee Hansard*, 25 October 2012, pp. 1-3.

10 Soldier B, *Committee Hansard*, 25 October 2012, pp. 4-7.

11 Sergeant (Sgt) Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, pp. 25-26.

12 Soldier N, *Committee Hansard*, 26 March 2013, p. 2.

13 Name withheld, *Submission 40*, p. 1.

14 Name withheld, *Submission 9*, p. 1.

injuries;<sup>15</sup> aircraft accidents and resultant serious, life-threatening/-changing injuries;<sup>16</sup> knee injuries;<sup>17</sup> back injuries incurred on exercise;<sup>18</sup> and bulged disks and ankle injuries,<sup>19</sup> and other back injuries,<sup>20</sup> caused by the requirement to carry heavy loads.

- 1.14 A large number of witnesses and submissions testified to the debilitating effects of anger, depression, post-traumatic stress, post-traumatic stress disorder (PTSD), and other mental health issues,<sup>21</sup> and this will be addressed at length in the report.

‘You won’t be soldiering on. You’ve got PTSD.’ They explained it all to me, and they went through the checklist of all the symptoms: the lockjaw, the anger, the shakes, the shortness of breath, the sleepless nights – I was getting on average two hours sleep a night – the recurring dreams and everything.<sup>22</sup>

- 1.15 The Committee unreservedly salutes these and every other service member wounded or injured on operations, whether physically or psychologically, and thanks them for their service and sacrifice.

## Issues

- 1.16 The issues considered in the course of the Inquiry included whether the support systems for ADF personnel wounded on Operations are adequate both immediately after injury and during return to Australia.
- 1.17 It also considered whether the ongoing support and care for ADF personnel wounded on Operations provided by Defence and DVA is
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15 Name withheld, *Submission 14*, p. 1.

16 Soldier On, *Submission 15*, p. 10.

17 Name withheld, *Submission 16*.

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

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

20 Soldier J, *Committee Hansard*, 26 March 2013, p. 1; Soldier K, *Committee Hansard*, 26 March 2013, p. 1; Soldier L, *Committee Hansard*, 26 March 2013, p. 1; Soldier P, *Committee Hansard*, 26 March 2013, p. 2.

21 Name withheld, *Submission 2*, p. 1; Name withheld, *Submission 6*, pp. 1–2; Name withheld, *Submission 14*, p. 1; Name withheld, *Submission 16*, p. 1; Soldier A, *Committee Hansard*, 25 October 2012, p. 2; Soldier B, *Committee Hansard*, 25 October 2012, p. 4; Soldier E, *Committee Hansard*, 25 October 2012, p. 8; Soldier F, *Committee Hansard*, 25 October 2012, p. 11; Soldier I, *Committee Hansard*, 25 October 2012, p. 9; Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 25; Mr Michael Gunther Baron von Berg MC, Veterans Advisory Council of South Australia, *Committee Hansard*, 8 February 2013, p. 26; Soldier L, *Committee Hansard*, 26 March 2013, p. 2; MAJGEN (Retd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 1.

22 Soldier F, *Committee Hansard*, 25 October 2012, p. 13.

adequate. The Committee also examined how these individuals are transitioned back into the workplace, where possible, or into civilian life if they can no longer return to service.

## Aim

- 1.18 The aim of the Inquiry was to ensure that appropriate systems and processes are in place to optimise the potential for ADF personnel wounded or injured on Operations to return to active duty or, at the very least, to lead a satisfying and productive life post-wounding.

## Definitions

### Wounded

- 1.19 For the purpose of the Inquiry, any ADF member who is serving in war-like conditions and is hurt during contact with the enemy is said to have been 'wounded'.

### Injured

- 1.20 For the purpose of the Inquiry, any ADF member hurt in an incident that has not been the result of enemy action in warlike conditions is said to have been 'injured'.
- 1.21 Defence advises that they use a similar series of definitions, submitting that an ADF member who is serving in war-like conditions and is hurt during contact with the enemy is said to have been 'wounded' and is defined as a battle casualty. An ADF member who is hurt in an incident on operations that has not been the result of enemy action is said to have been 'injured' and is defined as a non-battle casualty. Defence submitted that the management of wounded and injured is the same regardless of cause and follows the same medical treatment system.
- 1.22 Defence also submitted that psychological injury is currently their most difficult area for the provision of health care and the lessons learnt in Operation SLIPPER have been and are applied to other operations and exercises.<sup>23</sup>
- 1.23 The Committee has not needed to distinguish between individuals based on whether they were wounded or injured in relation to their post-incident care, rights or treatment.

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23 Department of Defence, *Submission 17*, p. 9.

## Committee comment

- 1.24 The Committee notes the Defence definition of psychological battle casualties, however as shall be seen in the course of this report, the Committee highlights that psychological damage from a combat incident can manifest much later than one month after exposure.

## Conduct of the Inquiry

- 1.25 The Committee received 36 submissions and five supplementary submissions from organisations and the general public. Published submissions are available on the Committee's website. A list of all submissions and exhibits is included at Appendixes A and B.
- 1.26 After hearing from Defence and DVA, the two Departments most responsible for care of wounded and injured veterans in Canberra on Tuesday 9 October 2012, the Committee travelled to Darwin to conduct its first closed hearing to talk to two roundtable groups of soldiers. One group involved soldiers hurt during contact with the enemy – wounded soldiers – and one involved soldiers hurt in an incident not as a result of enemy action but still in warlike conditions – injured soldiers – in order to understand the impact on the individual.
- 1.27 The Committee then commenced a series of public hearings involving organisations supporting wounded and injured ADF or former-ADF members in Canberra, Melbourne, Adelaide and Brisbane. In all 59 individuals came before the Committee to give evidence. The list of witnesses is at Appendix C.
- 1.28 The Committee also invited Major General (MAJGEN) (Retired) John Cantwell AO DSC to give evidence regarding his personal, and now public, battle with PTSD, as detailed in his recently published book *Exit Wounds*. General Cantwell, a former Commander of Australian Forces in the Middle East Area of Operations (MEAO) and Deputy Chief of Army, gave very compelling evidence and the Committee thanks him for his candour.
- 1.29 The Committee asked both Defence and DVA to reappear later in the Inquiry in order to discuss some of the issues that had arisen during the evidence gathering process, and finished up in Brisbane where it had begun, talking to wounded and injured soldiers.
- 1.30 The Committee has been mindful to remember that recovery from wounds and injuries, both visible and invisible, is an issue facing thousands of

Australians, and importantly their families, who have volunteered to risk their lives in the national interest.

## Structure of the report

- 1.31 The report is structured in a chronological order which broadly reflects the terms of interest.
- 1.32 Chapter two begins by detailing the responsibilities of the Defence and DVA in the care of wounded and injured soldiers. It then follows the path of the wounded or injured soldier from provision of first aid in the immediate aftermath of their injury, their transport to a medical facility, and the in-theatre care provided to them. It considers the preparation individuals receive prior to deployment, and begins to address how families of the wounded and injured are included in the repatriation and recovery process.
- 1.33 Chapter three investigates the aeromedical evacuation process, be it via Germany as is sometimes the case dependent on the severity of the injuries, or direct to Australia. It also looks at the case management and support provided to the family. It also considers the tax and leave entitlement implications of an early return to Australia for the wounded soldier.
- 1.34 Chapter four addresses the rehabilitation of physical injuries, Defence health care responsibilities, and rehabilitation and support programs available to the individual.
- 1.35 Chapter five looks specifically at mental health issues, including PTSD and also at broader mental health concerns. It considers psychological rehabilitation, support provided to families and looks at an Army initiative that combines physical and mental rehabilitation. It also considers how mental health fits within a military culture.
- 1.36 Chapter six considers the three main outcomes available to an ADF member wounded or injured on Operations; a return to work, re-mustering to a generally less demanding specialisation, or discharge from the ADF. It looks at the medical classification process and related policy, and begins to closely consider the role that DVA plays in the recuperation process and looks at some options for improving identification of service related illness and access to health care.
- 1.37 Chapter seven considers the veteran who returns from operations and, knowingly or unknowingly, is carrying physical or mental scars for which they do not receive treatment. It looks at the topical issue of delayed onset mental health conditions.

- 1.38 Chapter eight looks more closely at the role of the DVA, their claims and compensation process, longer term support infrastructure and case management.
- 1.39 Chapter nine ends the report with an acknowledgment of the many organisations in Australia, many of which contributed to the Inquiry, that directly or indirectly support our wounded and injured veterans, and looks at some wider support considerations.



## Immediate Action

- 2.1 This chapter addresses the action taken immediately, following a wounding or injury, on operations. It follows the immediate first-aid, the helicopter ride back to medical support, the phone call to the family and the first in-theatre medical treatment. It considers preparation individuals receive prior to deployment, and the importance of families in the repatriation and recovery of the individual.

## Responsibilities

- 2.2 The Department of Defence (Defence) summarised their responsibilities, noting that the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the Australian Defence Force (ADF) member may be posted. The Surgeon General Australian Defence Force/Commander Joint Health is responsible for the technical control of ADF health services.
- 2.3 The provision of health care to ADF personnel does not start when an individual is injured or wounded, and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation – pre-deployment, provision of treatment and evacuation during deployment and post-deployment.
- 2.4 When ADF personnel are injured or wounded, there is a reasonable expectation that they will receive prompt and effective health care which meets contemporary Australian standards and this underpins the continuum of care that is provided to the men and women of the ADF.<sup>1</sup>

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1 Department of Defence, *Submission 17*, p. 9.

Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force (CDF), told the Committee:

The provision of health care to ADF personnel is a continuum from enlistment through to transition from the ADF back into civilian life.<sup>2</sup>

- 2.5 The Department of Veterans' Affairs (DVA) submitted that each injury is unique in terms of effects on the person and their family, and the care and support they need. DVA takes full responsibility for care and support for those wounded or injured personnel who leave the ADF.<sup>3</sup>

## **Combat first aid**

- 2.6 Defence submitted that, that the type of treatment received in-theatre is based on the severity of wounds or injuries. Treatment can obviously be complicated by the tactical situation, particularly if troops are still engaged with the enemy.
- 2.7 Defence advised that the casualty treatment process is layered to provide the best possible care for Australian troops. All Australian soldiers are trained in basic first aid. Initially casualties are provided first aid or administer self-aid with combat medical supplies they carry themselves, within ten minutes of being wounded where possible.
- 2.8 During force preparation training at Al Minhad Air Base, all personnel deploying into Afghanistan receive refresher training in first aid that includes the management of catastrophic haemorrhage and airway management. The care of battle casualties training is conducted in a simulated battlefield scenario and provides personnel with the opportunity to refresh their skills immediately prior to going into combat. In the event of battle casualties, personnel can then correctly apply the lifesaving medical supplies provided to them.<sup>4</sup>
- 2.9 During initial first aid, an assessment is made as to the severity of the wounds and injuries and if required, the soldiers will then call for additional medical support or an evacuation of the wounded or injured person.
- 2.10 Tactical units may also include combat first aid trained personnel who have received advanced training in the initial treatment of wounds likely to be encountered on a battlefield. Special Forces patrols often include a

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2 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1.

3 Department of Veterans' Affairs, *Submission 18*, p. 9.

4 Department of Defence, *Submission 17*, p. 11.

Patrol First Aider or Advanced Combat First Aider. These soldiers are trained in advanced first aid procedures and are similar to paramedics in the civilian sense.

2.11 If required, the wounded or injured person will be evacuated to a medical facility for further treatment. This evacuation is conducted by the most suitable and expedient means and this is most usually by helicopter. Timings for aeromedical evacuation in Afghanistan are based on medical severity. For life-threatening wounds or injuries the following timings are mandated by the International Security Assistance Force (ISAF) and have been endorsed by Australia:

- Evacuation assets aim to reach seriously wounded soldiers within one hour of wounding, and provide en-route care based on the clinical needs of the patient. This one hour guidance is not always possible when the tactical situation delays evacuation.
- All attempts are made to evacuate casualties to a medical facility able to provide surgery within two hours of wounding. This is the basis for the 10:1:2 rule – first aid within ten minutes, advanced resuscitation within one hour and surgery within two hours of wounding.
- For non-life threatening wounds the timings are extended, although in many cases the evacuation process is such that the same timings result.<sup>5</sup>

2.12 The Committee received a body of evidence relating to the immediate care of wounded or injured soldiers in the operational area as being exceptional<sup>6</sup> and world best,<sup>7</sup> for which the Committee commends the Department of Defence.

2.13 This sentiment was frequently echoed, for example the Returned and Services League of Australia (RSL) Victorian Branch highlighted the lifesaving skills of combat medics on the ground in Afghanistan:

Their skills have ensured greater survivability odds for their colleagues. The Branch believed that the tried and true method of air medical evacuation to the nearest medical treatment centre in the theatre of operations has saved lives.<sup>8</sup>

## Pre-deployment training

2.14 Defence advised that the initial response at the point of injury is crucial. The provision of bleeding and airway control for the most seriously

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5 Department of Defence, *Submission 17*, pp. 11-12.

6 Name withheld, *Submission 2*, p. 2.

7 Vietnam Veterans' Association of Australia, *Submission 27*, p. 3.

8 Returned and Services League of Australia, *Submission 11*, p. 4; Young Diggers, *Submission 22*, p. 1.

injured must take place within 10 minutes of injury. To provide this, combat personnel (non-health personnel) are trained and competent to deliver enhanced first aid, principally to stop bleeding and secure the airway.

- 2.15 Every member of the ADF routinely receives training in first aid with an emphasis on the skills required in a military environment. Selected members are provided with advanced first aid skills tailored to their Service environment and are periodically refreshed as part of the normal training cycle. These include:
- the Minor War Vessel Medical Care Provider Course;
  - the Combat First Aid Course; and
  - the Patrol Advanced First Aiders Course.<sup>9</sup>
- 2.16 Based on the risk associated with the operational deployment there is further tailored refresher and skills extension training conducted at all levels of the first aid and emergency medical response. For forces deploying into Afghanistan the pre-deployment training is conducted under the Exercise Primary Survey framework. All members are trained and assessed in Care of the Battle Casualty with significant resources being utilised to create realistic combat scenarios where the skills in management of combat injuries are developed and assessed by experienced medical observers.
- 2.17 Defence submitted that Combat First Aiders, Patrol Advanced First Aiders and deploying health staff conduct additional high fidelity training focused on comprehensive pre-hospital treatment and evacuation. The training is overseen by both military and civilian trauma specialists and adapted to reflect current best practice. Scenarios are based on the experiences of health staff that have recently returned from Afghanistan. The final component of the exercise series targets the health staff, refreshing and enhancing their trauma skills. It involves live tissue training and challenging simulated resuscitation drills overseen by military trauma specialists.
- 2.18 During Reception, Staging, Onward Movement and Integration (RSO&I) in Al Minhad Air Base, all members deploying into Afghanistan receive further high fidelity refresher training in Care of the Battle Casualty. This training is delivered by a contractor utilising ex-serving, combat experienced medics and overseen by ADF health staff. It involves a combination of lectures, individual skill refresher stations with an emphasis on control of massive haemorrhage, and extraction of casualties resulting from an improvised explosive device strike. The training
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9 Department of Defence, *Submission 17*, p. 5.

- culminates in an assessment of all skills within a realistic simulated battlefield environment.
- 2.19 Whilst deployed, members receive ongoing refresher training often conducted in conjunction with range firing practices. Training focuses on maintaining currency in the application of the Combat-Application-Tourniquet (CAT) and production of the North Atlantic Treaty Organization (NATO) medical evacuation request. This is a message that is transmitted quickly to request an urgent medical evacuation and contains information that includes: the condition; number and nationality of the casualties; their location; what special equipment will be required; and the conditions on the ground that might inhibit their extraction.
- 2.20 Combat First Aiders and health staff maintain their skills by routinely participating in the Role 2E trauma roster and by augmenting during multiple casualty incidents. The currency and competency of first aiders and health staff are regularly tested with real time trauma patients. Defence submitted that coalition partners have consistently observed that the quality and responsiveness of Australian first aiders and health staff in trauma cases is first class.
- 2.21 Specialist health personnel are qualified, current and competent in their clinical and operational skills and must meet the credentialing requirements of Australia and coalition partners.<sup>10</sup>

### In-theatre health facilities

- 2.22 The operational health care system provides for the continuum of care from initial first aid via a dedicated evacuation chain to increasing levels of specialist health care delivery. This system is organised into roles of health care, which range from first aid through to definitive health care and rehabilitation. Roles of health care extend from the point of injury or illness providing continuous care to casualties. Each tier has increasingly sophisticated treatment capabilities and each casualty is treated at the most appropriate role of health care. This may involve either movement through the care continuum or casualty evacuation to the most appropriate health facility.<sup>11</sup> Lieutenant Colonel (LTCOL) Michael Reade, Defence's Professor of Military Medicine and Surgery, told the Committee that:

The trauma care is excellent. It is a trauma system that has evolved dramatically in the last 12 or so years. I think it would be fair to say it was something in need of development at the start but

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<sup>10</sup> Department of Defence, *Submission 17*, pp. 4-5.

<sup>11</sup> Department of Defence, *Submission 17*, p. 6.

that development has been very actively pursued. I think it is a more responsive trauma system; that would be true of any civilian system anywhere in the world. ... It is responsive to the operational need, it is very well resourced and it is comprehensive in its care. It is very much focused on getting people out of the deployed environment quickly.<sup>12</sup>

- 2.23 Defence submitted that a Role 1 health facility provides primary health care, triage and basic resuscitation and stabilisation in the theatre of operations.
- 2.24 A Role 2 health facility provides enhanced clinical support based on formed health teams and is capable of advanced resuscitation and treatment of casualties prior to evacuation.
- 2.25 A Role 2 enhanced (Role 2E) health facility provides secondary health care built around primary surgery, intensive care and nursed beds and treats and prepares casualties for evacuation to a Role 3 health facility or directly out of theatre.
- 2.26 A Role 3 health facility provides comprehensive secondary health care including primary and specialist surgery, major medical and nursing services and casualty holding for treatment and return to duty.
- 2.27 A Role 4 health facility offers the full spectrum of definitive care and is provided from or within the national support base.<sup>13</sup>

## ADF responsibility

- 2.28 The ADF is responsible for the provision of Role 1 health support to ADF elements in the Middle East Area of Operations (MEAO). Role 2 support is provided at the ADF health facility at Al Minhad Air Base and Role 2E support is provided at the United States (US) led ISAF facility in Tarin Kot. Role 3 health support is provided to ADF members at the Multinational US led ISAF facility at Kandahar. Role 4 health support is provided from either the US Landstuhl Regional Medical Center in Germany or from Australian tertiary civilian hospital facilities.<sup>14</sup>

## Public information during incidents

- 2.29 The Minister for Defence provides information on broad categories of injuries sustained by our troops in his regular Ministerial Statements to Parliament.
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12 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

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

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

2.30 Defence aims to provide public information on every operational incident involving battle casualties (wounded and killed in action). Operational tempo, ongoing operations and Special Operations are three factors which may lead to occasional inconsistency in reporting. Media information about casualty figures is however updated as appropriate, when operational circumstances permit. Defence guidance on the release of public information during incidents includes:<sup>15</sup>

- The ADF will not release the names of casualties until Next of Kin (NOK) procedures have been completed.
- The ADF will not comment on the circumstances or causes of an incident until any investigation has been completed and if it is likely to be subject to disciplinary proceedings.
- In order to align with the civilian practice for reporting patient medical condition without compromising the medical-in-confidence nature of the wounds and injuries, Defence has adopted a nomenclature for public information relating to battle casualties:
  - ⇒ Life Threatening. Injury and wounds that will likely lead to death if not immediately treated (for example, fragmentation and gunshot wounds involving vital organs or the head). Also applicable to an illness requiring admission to an intensive care facility.
  - ⇒ Serious. Injury and wounds requiring immediate medical care and hospitalisation but not considered life threatening (for example, fragmentation and gunshot wounds to torso). Also applicable to an illness requiring hospitalisation.
  - ⇒ Slight/Minor. Injury and wounds requiring medical care and hospitalisation (for example, fragmentation and gunshot wounds to the extremities). Also applicable to an illness requiring basic medical care/monitoring and restriction of duties.
  - ⇒ Superficial. Injury and wounds not requiring hospitalisation.<sup>16</sup>

## Notification of casualty

2.31 Notification of casualty (NOTICAS) is the name for the formal reporting of casualties within the ADF. This reporting informs the chain of command and provides information that is passed to families of deployed personnel. NOTICAS reports are raised for every wounding and the reporting is undertaken as quickly as possible.

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15 Department of Defence, viewed 4 April 2013, <[www.defence.gov.au/op/afghanistan/info/personnel.htm](http://www.defence.gov.au/op/afghanistan/info/personnel.htm)>.

16 Department of Defence, *Submission 17*, p. 12.

- 2.32 Defence submitted that notification of wounding or injury is raised as quickly as possible to ensure both the family and command chain is informed as soon as practicable. Contact between the member and the family also takes place as soon as possible.<sup>17</sup>
- 2.33 Defence Families of Australia (DFA) submitted that NOK need to be kept informed and included throughout the repatriation process in order to address and allay concerns of the NOK and to reduce the family's stress.<sup>18</sup>

## Public release of names

- 2.34 Defence advised the Committee that their policy regarding the release of the names of members wounded or injured is:<sup>19</sup>
- Names of ADF members (not afforded protected identity status) remaining in an operational area following an announced wounding or injury will not be released;
  - Names of ADF members (not afforded protected identity status) returning to Australia for treatment will remain protected until authorised for release by the individual member concerned while the names of ADF deceased will be released in consultation with the member's family;
  - Only Special Forces soldiers, who have protected identity status, may have their names withheld when they are admitted into non-military hospitals; and
  - There is no policy to hide the identity of other Australian soldiers undergoing medical treatment and rehabilitation in private or public hospitals.

## Medical evacuation

- 2.35 Defence submitted that the objective of casualty evacuation is the safe and efficient movement of casualties, with the provision of en route medical care, from point of injury or illness to the appropriate health facility as soon as possible. Evacuation comprises both surface evacuation and aeromedical evacuation.
- 2.36 The evacuation system aims to evacuate casualties 24 hours a day, in all weather, over all terrain and in any operational scenario. The system
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17 Department of Defence, *Submission 17*, p. 12.

18 Defence Families of Australia, *Submission 8*, p. 1.

19 Department of Defence, viewed 4 April 2013, <[www.defence.gov.au/op/afghanistan/info/personnel.htm](http://www.defence.gov.au/op/afghanistan/info/personnel.htm)>.



provides clinical sustainment of the casualty throughout the journey, using appropriately trained clinical staff and accurately tracks patients and equipment throughout the evacuation. Casualties are evacuated to the most appropriate facility in the shortest time while applying appropriate clinical processes.

- 2.37 This approach enables forward deployment of health elements and concentrates resource-intensive casualty care in more secure areas where health facilities are not required to move with changing tactical situations. Casualty regulation directs the casualty to the health facility that is best able to manage the condition in terms of nature and availability of required treatment. Regulation ensures proper routing of patient to health facilities and minimises casualty handling and transfer. In the MEAO, aeromedical evacuation of a patient from the scene of injury or illness to the initial treatment facility and evacuation of a patient between health facilities within the area of operation is the responsibility of coalition partners.<sup>20</sup>
- 2.38 Australians serving in Uruzgan rely on a team of highly skilled US and Australian trauma and medical staff working in a well-equipped ISAF Role 2E health facility in Tarin Kot. This facility performs initial trauma management similar to that provided by the emergency department of a civilian hospital and if required, the facility can also undertake emergency surgery to treat the wounded or injured.<sup>21</sup> One soldier who was evacuated commented that the American medical staff were 'really good.... they were really helpful'.<sup>22</sup>
- 2.39 Not everyone who is wounded or injured requires evacuation, and those ADF members who suffer only minor physical impairment are treated and, once fit, return to duty.
- 2.40 Casualties that require more specialist care than can be provided at the Role 2E at Tarin Kot are evacuated to the Kandahar Role 3 Multinational Medical Unit (MMU). Depending upon the treatment required, casualties may receive further surgery, be clinically stabilised, and/or provided supportive care. The facility is predominately staffed by US health specialists but is currently being augmented by ADF specialist reserve staff. The ADF has a general surgeon, anaesthetist, orthopaedic surgeon, two perioperative nurses and two intensive care nurses embedded in this facility.

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20 Department of Defence, *Submission 17*, p. 7.

21 Department of Defence, *Submission 17*, p. 12.

22 Soldier J, *Committee Hansard*, 26 March 2013, p. 9.

- 2.41 Once stabilised, seriously wounded or injured personnel will be returned to Australia for additional treatment and rehabilitation which is managed by Joint Health Command.<sup>23</sup>

## Operational health support

- 2.42 Defence informed the Committee that the ADF provides comprehensive health services whether the environment is permissive, uncertain or hostile. In addition to caring for Defence personnel, ADF health elements may provide humanitarian health care to a civilian population in higher threat environments until the situation has sufficiently stabilised for handover to civilian providers.
- 2.43 Military health support is commensurate with force strength and assessed health risks and is designed to ensure that appropriate treatment and evacuation capabilities exist to maximise the early return to duty of casualties. Support starts before deployment and expands as the force strength expands and risks increase. It focuses on both battle casualties as well as disease and non-battle injuries. Health support has a surge capacity to support peak casualty periods.
- 2.44 As noted previously, when ADF personnel are injured or become ill, there is an expectation that they will receive prompt and effective health care. ADF health care meets contemporary professional Australian standards except when the exigencies of military operations dictate otherwise.<sup>24</sup> LTCOL Reade told the Committee that ADF medical staff volunteering for deployment to Afghanistan had shown 'quite a depth of skill and were willing contributors'.<sup>25</sup>
- 2.45 LTCOL Reade went on to explain that it would be very expensive to train a contract health practitioner to be able to go to Afghanistan and deal with that high-level, high-intensity everyday trauma that is being experienced.<sup>26</sup>

## Committee comment

- 2.46 The Committee acknowledges Defence's submission that management of the wounded and injured in Afghanistan is currently the most difficult
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23 Department of Defence, *Submission 17*, p. 12.

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

25 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

26 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 26.

area for the provision of health care and the lessons learnt in this operation have been, and are applied to, other operations and exercises.

- 2.47 The Committee agrees that it is not appropriate for Defence to provide more specific details on an incident immediately due to medical-in-confidence and privacy reasons and that, where possible, contact with the NOK takes precedence over all other considerations.
- 2.48 The Committee also agrees with the general Defence policy regarding the release of the names of members wounded or injured.



## Aeromedical Evacuation

- 3.1 This chapter considers the aeromedical evacuation (AME) process and continues to highlight the importance of family in repatriation and recovery.
- 3.2 It also discusses the tax and leave entitlement implications of an early return to Australia for a wounded soldier when compared to the soldier's compatriots who remain in theatre on operations.

### **Australian aeromedical evacuation capability**

- 3.3 Defence submitted that Australian Defence Force (ADF) Aviation Medical Officers, located at Kandahar Air Field in Afghanistan, are responsible for coordinating the AME of ADF casualties by either ADF aircraft, or through the United States (US) AME system. Casualties evacuated by ADF aircraft are provided medical care in the air by the Royal Australian Air Force (RAAF) personnel.<sup>1</sup> One soldier aeromedically evacuated commented that:

My treatment has been awesome. ... That is across the board from the AME team that brought me home on day two, to the doctor, the psychologist and psychiatrist that I have here in town now.<sup>2</sup>
- 3.4 Patients requiring transfer to the US Role 4 Landstuhl Regional Medical Center are evacuated by the US AME system. They are cared for by US

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1 Department of Defence, *Submission 17*, p. 7.

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

medical personnel, and supported by a dedicated ADF AME-trained RAAF nursing officer throughout the conduct of their AME.<sup>3</sup>

## **AME direct to Australia**

- 3.5 Defence submitted that ADF members who require return from operational areas for medical reasons are evacuated to Australia via the Air Force strategic AME system. The AME system seeks to ensure that members are evacuated in a safe and appropriate manner. It also provides a valuable patient tracking function ensuring that returning members are identified to the ADF medical system, Defence Community Organisation (DCO) and their chain of command for management and support.<sup>4</sup>
- 3.6 Air Marshal (AIRMSHL) Mark Binskin AO, Acting Chief of the Defence Force (CDF), told the Committee that Defence's aeromedical evacuation teams are 'second to none', and provide first-class care when bringing Australia's wounded and injured home.<sup>5</sup>
- 3.7 Once it is known that an ADF member has been wounded or injured, Joint Health Command liaise with Headquarters Joint Operations Command (HQJOC), the Air Operations Centre (an Air Force element embedded within HQJOC) and health staff within the area of operations to ensure that the wounded or injured member is repatriated to the most appropriate health facility. This could be a Defence health facility or a public or private hospital, depending on the nature of the condition and requirements for health care.<sup>6</sup> Lieutenant Colonel (LTCOL) Michael Reade, Defence's Professor of Military Medicine and Surgery told the Committee:

The provision of that care has also become excellent. Again, it was not initially. We would not have the facility, for example, at the outbreak of all of this to return a critically ill mechanically ventilated patient to Australia but we have now the airframes, we have got the medical equipment that is compatible with those airframes and we have got the trained and now experienced clinicians to do that. So it is really an outstanding medical system up until the point of return to Australia.<sup>7</sup>

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3 Department of Defence, *Submission 17*, pp. 7-8.

4 Department of Defence, *Submission 17*, p. 13.

5 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1.

6 Department of Defence, *Submission 17*, p. 13.

7 LTCOL Michael Reade, Professor of Military Medicine and Surgery, *Committee Hansard*, 25 March 2013, p. 24.

- 3.8 Wounded or injured personnel are repatriated to a facility within their home area where possible; however this depends on the nature of the wounds or injuries and the services available at that location. Access to family and their Unit/Service support is also considered in the return to Australia planning.<sup>8</sup>
- 3.9 On return to Australia, medical/clinical management of the care of the wounded or injured individual is transferred to Garrison Health Operations, and a comprehensive range of clinically appropriate health care is delivered through one of the five Regional Health Services. As previously stated, the overall responsibility for ensuring the support and welfare of the member remains with the member's Commander.<sup>9</sup>

## AME via Germany

- 3.10 While most wounded or injured ADF members can be directly returned to Australia, members who become critically ill or injured while in the Middle East Area of Operations (MEAO) may be evacuated by the US AME system to the US Role 4 Military Hospital in Germany.<sup>10</sup> The AME Operations Officer situated in Afghanistan and the Aeromedical Evacuation Control Centre (AECC) would assist in this transfer decision. This AME is usually by the US AME system on a dedicated tactical C-130 AME flight to Bagram, then by strategic C-17 AME flight to Germany. If a delay in Bagram jeopardises the clinical situation, a C-17 could be used from any Role 3 health facility for direct transport to Germany.
- 3.11 The AME Officer in-theatre is responsible for coordinating the AME of ADF members to Germany. HQJOC AECC is then responsible for organising the subsequent AME to return members to Australia when clinically appropriate.
- 3.12 ADF casualties who enter the US AME system are all provided with an ADF medical escort. Within the MEAO there is an AME Liaison Officer whose primary role is to provide this escort duty. Other ADF escorts may also accompany casualties transferred to Germany, such as a unit representative to provide emotional support and assistance to the patient.
- 3.13 When a casualty arrives in Germany, the AME liaison role is then transferred to another AME trained liaison officer who has been dispatched from Australia. Typically this liaison officer is an AME and

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8 Department of Defence, *Submission 17*, p. 13.

9 Department of Defence, *Submission 17*, p. 15.

10 Department of Defence, *Submission 17*, p. 13.

aviation nursing qualified registered nurse, or depending on complexity of the case, an additional AME and aviation medicine qualified medical officer may also be required.

- 3.14 The presence of an ADF medical liaison officer ensures that there is direct communication of clinical details throughout the AME process, as well as visibility of the patient's movements and ensures that the member is never left without support or contact with the ADF. The liaison officer provides clinical updates and advice on the patient's 'fitness to fly' for strategic AME. They also provide assistance to any next of kin who may travel to Germany. They are integral to the AME planning process, providing accurate and timely clinical information and usually form part of the AME retrieval team to Australia.<sup>11</sup>
- 3.15 Defence advised that the US AME system had facilitated the movement of four Australian casualties in 2012. These personnel transited through Landstuhl Regional Medical Center for a period of approximately seven days, before their evacuation to Australia. Their medical care at Landstuhl included surgery, multiple investigations, wound care, and intensive and general nursing care.
- 3.16 Care in Landstuhl is directed towards improving casualty outcomes and expediting their return to Australia. While at Landstuhl casualties are supported by Australian health personnel and commonly members from their Unit.<sup>12</sup>

## Case management

- 3.17 Defence advised that an individual's case is managed through the Member Support Coordination system which is designed to ensure that:
- the member:
    - ⇒ remains the central focus of support;
    - ⇒ is supported effectively;
    - ⇒ has, in the Member Support Coordinator, a single point of contact with whom they may turn to for assistance, support and guidance (but not specialist advice);
    - ⇒ understands the support and services available to them and their family;
    - ⇒ receives coherent and coordinated support tailored to their needs;
    - ⇒ understands their obligations during the period of support;

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11 Department of Defence, *Submission 17*, pp. 13-14.

12 Department of Defence, *Submission 17*, pp. 7-8.



- ⇒ is provided with all the information and specialist advice needed to make sound and timely judgements;
  - the member's Commander is provided with the resources, support and access to the additional skills required to ensure the facilitation and coordination of all necessary support.
- 3.18 Member Support Coordination arrangements are established to support individual cases where there are complex circumstances and comprise:
- the member and their family;
  - the member's Commander, who remains responsible to the relevant Chief of Service for the continued support and wellbeing of the member;
  - a Member Support Coordinator;
  - a Healthcare Coordinator; and
  - all health and administrative agencies and service providers, both within and external to Defence, who are engaged with, or support, the member.<sup>13</sup>

## Family support

- 3.19 The Defence Community Organisation provides emotional and practical support to the family in the form of social work and counselling or referral to appropriate community support and services.<sup>14</sup>
- 3.20 Defence advised that DCO administers the Australians Dangerously Ill Scheme that allows for a nominated family member or close friend to access financial assistance to visit and support an ADF member who has been hospitalised through serious wounding, injury or illness. The DCO facilitates the movement of eligible family members under this scheme to visit their wounded family member who has been evacuated to Germany. Family members are usually accommodated at one of two US military supported 'Fisher Houses' immediately adjacent to the Landstuhl Regional Medical Center.
- 3.21 Fisher House is a non-profit social service providing a 'home away from home' for family members of ill/injured patients and is located within walking distance of the treatment centre. The homes have been built by the Fisher House Foundation and given as gifts to the United States military Services. The houses are manned six days a week to help family

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<sup>13</sup> Department of Defence, *Submission 17*, p. 10.

<sup>14</sup> Department of Defence, *Submission 17*, p. 15.

members endure the stresses associated with a loved one's serious medical condition. Social workers are also available throughout the week.<sup>15</sup>

- 3.22 Defence Families of Australia (DFA) submitted that in the event of a multiple casualty incident requiring more than one family being flown overseas at the same time, that one case worker or support officer per family is required.<sup>16</sup>
- 3.23 Defence advised that in 2012 the ADF made a donation of \$225,000 to the Fisher House Foundation in recognition of the outstanding support provided to ADF families during these difficult times.<sup>17</sup>

### **Recommendation 1**

**The Committee recommends that the Department of Defence continue to make regular contributions to Fisher House as an ongoing measure of Australia's appreciation for the service provided to our wounded soldiers, until such time that Australian soldiers are no longer deployed to Afghanistan.**

- 3.24 Defence advised the Committee that DCO works closely with the military chain of command to manage the support requirements of the member and their family to ensure the wounded or injured member has the best chance of recovery and the family is adequately supported to reduce their stress.<sup>18</sup>
- 3.25 DFA highlighted the importance of provision being made for next of kin to visit the member if repatriation to home locality is not immediately possible (or at least access to communications), no matter where rehabilitation is to occur.<sup>19</sup>
- 3.26 The Returned and Services League of Australia (RSL) National Office advised that it regularly supports deployed personnel through its RSL Australian Forces Overseas Fund (AFOF) which provides a package twice a year to every serving member overseas, including those who required treatment through the NATO medical facilities in Germany.<sup>20</sup>

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15 Department of Defence, *Submission 17*, p. 14.

16 Defence Families of Australia, *Submission 8*, p. 1.

17 Department of Defence, *Submission 17*, p. 14.

18 Department of Defence, *Submission 17*, p. 14.

19 Defence Families of Australia, *Submission 8*, pp. 1-2.

20 Returned and Services League of Australia, *Submission 11*, p. 6.

## Return to Australia from Germany

- 3.27 Identification and confirmation of the most appropriate destination medical facility, for the patient on return to Australia is done in consultation with the patient, next of kin, Joint Health Command and the member's respective Service. The most suitable means for the AME is identified by the AECC; military air, civilian charter or civilian airline, using standard or critical care (Military Critical Care Aeromedical Team) AME teams as appropriate. This is intended to ensure the patient receives appropriate care and is returned safely to Australia.
- 3.28 Most AME returns from the MEAO and Germany can be conducted on civilian airlines using RAAF AME teams. When this is not appropriate, ADF aircraft can be utilised. Defence advised that in the last two years, the RAAF has conducted two multi-casualty AME retrievals of injured ADF members from Germany. In both cases, these AME missions involved multiple patients with complex care requirements, including intensive care type support. These missions were conducted on C-17 aircraft using both Permanent Air Force and Reservist AME trained personnel, and the dedicated C-17 AME equipment suites.
- 3.29 There have also been several C-17 AMEs conducted directly from the MEAO when the patients were not suited to other available means of transport.<sup>21</sup>

## Tax implications

- 3.30 The Veterans' Advisory Council (VAC) of South Australia expressed concern at the inequity that appears to exist between the way wounded soldiers who are returned to Australia are taxed, and the way other soldiers who remain on active service deployment are treated for tax purposes.
- 3.31 Under current arrangements, a soldier in this situation is entitled to receive their tax-free salary and accrue War Service Leave while in hospital, but not during outpatient treatment or rehabilitation. This means that any soldier wounded in action also suffers a financial detriment relative to soldiers continuing their deployment. This is felt most by a soldier who is wounded early in a tour of duty. A soldier in this situation would lose all tax-free pay and allowances after leaving hospital in Australia, thereby not only suffering physically and mentally in the line

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21 Department of Defence, *Submission 17*, p. 14.

of duty, but also financially. Sergeant Craig Hansen, 7th Battalion Royal Australian Regiment, commented that:

Maybe that is a little bit unfair because my mates, my soldiers, are still in Afghanistan and I am here through no fault of my own.<sup>22</sup>

- 3.32 The VAC's suggested solution was that wounded soldiers medically evacuated to Australia remain on the same taxation arrangement as those remaining in-country until they return to Australia.<sup>23</sup> Sgt Hansen, who was one of the first soldiers injured in Afghanistan, has had a private tax ruling agreeing that the income he earned in Australia from the date of his discharge from hospital until the expected end date of his overseas deployment, would be exempt from income tax in Australia under subsection 23AG(1) of the *Income Tax Assessment Act 1936* (ITAA 1936).<sup>24</sup>
- 3.33 The RSL's National Conditions of Service Committee also identified this as a critical problem. They similarly recommended that tax free status should be retained, particularly while the member is undergoing out-patient treatment and/or rehabilitation, for the notional length of the operational tour.<sup>25</sup>
- 3.34 As noted by the VAC, this loss of eligibility also applies to the accrual of War Service Leave for ADF members wounded or injured on operations and evacuated to Australia.<sup>26</sup>
- 3.35 VAC submitted that these recommendations would cost, based on an approximate average tax disadvantage per wounded soldier of \$5,000.00, a total of approximately \$1,200,000 for veterans of the Afghanistan campaign.<sup>27</sup> The Committee estimates that these soldiers could have accrued a total of approximately 500 additional leave days.

## Committee comment

- 3.36 The committee agrees with Young Diggers in that Australian repatriation arrangements are excellent and commends Australia's AME organisation for their efforts.

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22 Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 22.

23 The Hon. Jack Snelling MP, *Submission 13*, pp. 1-2.

24 Mr Michael (Baron) von Berg MC, Veterans Advisory Council of South Australia, *Committee Hansard*, 8 February 2013, p. 22.

25 Returned and Services League of Australia, *Submission 11*, pp. 5-6.

26 The Hon. Jack Snelling MP, *Submission 13*, pp. 3-4.

27 The Hon. Jack Snelling MP, *Submission 13*, p. 3.

- 3.37 The Committee agrees that soldiers repatriated from operations due to injuries or wounds sustained in the course of authorised activities are currently treated inequitably in terms of tax and leave entitlements. The Committee recommends that tax and leave arrangements be reformed to eliminate this inequity.

### **Recommendation 2**

**The Committee recommends that the Department of Defence and the Australian Taxation Office ensure that Australian Defence Force personnel medically evacuated to Australia retain tax free status for the notional length of their operational deployment, or the actual length of the deployment of their unit, per subsection 23AG(1) of the *Income Tax Assessment Act 1936*.**

### **Recommendation 3**

**The Committee recommends that the Department of Defence ensure that Australian Defence Force personnel medically evacuated to Australia continue to accrue War Service Leave and allowances for the notional length of their operational deployment, or the actual length of the deployment of their unit.**

- 3.38 These recommendations should apply from the moment a member qualifies for tax free status on departure on operational deployment

### **Recommendation 4**

**The Committee recommends that the Department of Defence and the Australian Taxation Office assist Australian Defence Force personnel previously medically evacuated, and to whom Recommendations Two and Three would have applied, to make successful retrospective claims for reimbursement.**



## A Badge of Honour

### Physical injuries

- 4.1 Chapter Four considers the rehabilitation process of Australian Defence Force (ADF) members who receive wounds and injuries while on operations. It also addresses broader Department of Defence (Defence) health care responsibilities, and the various rehabilitation and support programs available to assist members in their recuperation.

### Rehabilitation and recovery

- 4.2 Professor Peter Leahy AC highlighted to the Committee that:

For most Australians, Afghanistan is a long, long way away. We acknowledge the sacrifice of those who die, but I am not sure that we know just what is happening to those who come home wounded or, indeed, those who just come home and it has been pretty tough for them.<sup>1</sup>

- 4.3 Defence advised the Committee that within five to ten days of returning to Australia, a wounded or injured member is placed in the ADF rehabilitation program to manage all their health and rehabilitation requirements. The ADF rehabilitation program aims to:
- reduce the impact of injury or illness through early clinical intervention;
  - reduce any psychological effects of the injury;
  - return the member to suitable work at the earliest possible time; and

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1 Professor Peter Leahy AC, Chairman, *Soldier On*, *Committee Hansard*, 27 November 2012, p. 7.

- provide a professionally managed rehabilitation plan tailored to individual needs.<sup>2</sup>

## **Defence health care responsibilities**

- 4.4 Defence submitted that whilst the health and welfare of members is a command responsibility, which ultimately rests with the Chief of each Service regardless of where the ADF member may be posted, the Surgeon General Australian Defence Force/Commander Joint Health is responsible for the technical control of ADF health services. This includes all personnel involved in the provision of health care (which includes psychology services) within the ADF, the provision of specialist health advice, development of policy on health issues and delivery of all garrison health care.
- 4.5 Joint Health Command is responsible for the Defence health care system which is designed to prevent and minimise the impact of operational, environmental and occupational health threats and to treat ill, wounded and injured members. As previously noted, the provision of health care to ADF personnel does not start when an individual is wounded or injured and the Defence health care system provides a continuum of care from enlistment through to transition from the ADF and during all phases of an operation.
- 4.6 Components of this health care system include all routine and emergency health care within Australia, health promotion activities, pre-deployment fitness assessments, first aid and advanced first aid training for non-health personnel, operational health support in theatre, a tiered medical evacuation system and post deployment assessment and care, physical and occupational rehabilitation and mental health support.<sup>3</sup>
- 4.7 Defence submitted that Joint Health Command provides the standard of health care required in order to ensure the operational readiness of the ADF, and enable all personnel to perform their military duties. Defence has a commitment to managing the health consequences of operational service as well as providing health treatment to wounded and injured personnel.
- 4.8 Defence advised that Joint Health Command is required to provide to members of the Permanent Forces such health care as is deemed necessary

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2 Department of Defence, *Submission 17*, p. 15.

3 Department of Defence, *Submission 17*, p. 2.



to detect, cure, remove, prevent or reduce the likelihood of disease or infirmity which affects, or is likely to affect:

- The efficiency of the member in the performance of their duties; or
- Endangers the health of any other member; or
- Assists to rehabilitate the member for civilian life; and
- Restores the member, so far as is practicable, to optimal health in the ADF context.<sup>4</sup>

## Garrison health care

4.9 Defence's submission states that Joint Health Command is responsible for the ongoing health care of all ADF personnel when they are not operationally deployed. This includes specific health care needs such as routine health care, regular health checks, comprehensive vaccination programs, pre- and post-deployment screening, and health care to manage the physical, mental and social wellbeing of the fighting force to ensure they remain 'fit to fight'. Joint Health Command staff also maintains strong communication pathways with units and Commanders to ensure that the welfare and health needs of individuals are coordinated, comprehensive and well managed.

4.10 This suite of preventative and primary health care is delivered through five Regional Health Services across Australia. Each Regional Health Service has a number of Health Centres and Clinics which deliver healthcare and support to ADF personnel and Commanders to ensure continued operational capacity and capability of ADF personnel. Current health services delivered include primary health care, preventive health care, diagnostic testing, pharmaceutical supply, physiotherapy services, dental services, mental health and psychology services, access to specialist medical care, access to tertiary level inpatient services within the civilian local hospital/healthcare network, and rehabilitation services including specialised case management. Joint Health Command services are delivered by a wide range of practitioners including:

- Uniformed doctors, nurses, dentists, medics and allied health professionals from all three Services;
- Australian Public Service health practitioners within health centres and clinics;
- Contracted health providers who assist in the provision of many clinical roles;

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4 Department of Defence, *Submission 17*, p. 2.

- Reserve health practitioners who provide clinical services and specialist care; and
  - Civilian specialist health providers who provide advice and support to Joint Health Command practitioners while also providing specialist health care for ADF personnel.<sup>5</sup>
- 4.11 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health Command advised the Committee that on-base garrison health care services transitioned to the new service provider beginning in November 2012. She advised that the five service arrangements have transitioned successfully and that she was unaware of any ADF member who has not received health care for an urgent medical condition.<sup>6</sup>
- 4.12 Defence went on to advise the Committee that they are confident that:
- All garrisons have access to the required level of health services both on-base and off-base; and
  - Sufficient levels of outsourced arrangements are in place to ensure that ADF personnel continue to receive timely and clinically appropriate care within their locale.<sup>7</sup>
- 4.13 Defence acknowledged that throughout the contract term there will be workforce pressures for the on-base services due to critical workforce levels in the health industry, especially in remote localities and areas of need. The current percentage of positions filled is approximately 93 per cent nationally. Defence submitted that they and Medibank Health Solutions (MHS) continue to work together to ensure sufficient fill rates for on-base personnel are achieved across the garrison environment; and that ADF personnel continue to receive timely access to high quality health care.
- 4.14 Defence submitted that it is confident that ADF personnel have continued to receive timely, clinically appropriate care within their locale during the transition to the new off-base services arrangements. Whilst there were initial concerns regarding the sufficiency of the off-base service provider numbers, Defence and MHS claim to have worked through these concerns to ensure appropriate access for the ADF.
- 4.15 Defence said that MHS continue to monitor, review and grow the off-base service provider list and will do so through the life of the contract to ensure appropriate, timely access is available to the ADF; and also ensure that it is aligned with Defence's changing healthcare needs. Defence
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5 Department of Defence, *Submission 17*, p. 3.

6 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 7.

7 Department of Defence, *Submission 38*, p. 2.

advised the Committee that they will continue to work with MHS throughout the contract term to ensure ADF personnel have access to appropriate care through the off-base service provider arrangements.<sup>8</sup>

4.16 Defence went on to advise that they undertook a customer satisfaction survey from 1 August to 31 October 2012 which was intended to provide a baseline of customer satisfaction prior to entering into the ADF Health Service Contract. The next iteration of the survey is scheduled to commence in September 2013. The final report of the survey is still pending however the following data was provided. Of the 5,341 customers of ADF health services who provided a valid survey response about their visit:

- 82.8 per cent were seen within 30 minutes of their scheduled appointment;
- 34.6 per cent were able to get an appointment in less than one week;
- 23.4 per cent took more than three weeks to get a non-urgent medical appointment;
- 74.2 per cent agreed that access to the health service they required was available in a reasonable timeframe;
- 73.3 per cent indicated that they were satisfied or very satisfied with the health service provided; and
- 64.0 per cent agreed or strongly agreed that the overall quality of the health service they received was excellent.<sup>9</sup>

4.17 Mr Brian Freeman, the Director of Centori Pty Ltd, advised the Committee, however, that that 'nearly all' the hundreds of wounded and injured soldiers who have visited the Mates4Mates Family Recovery Centre say that the time it takes to get an appointment with the Defence system for treatment - 'mental, and even sometimes physical' - is too prolonged.<sup>10</sup>

4.18 At least one submitter felt that doctors and physiotherapists are dangerously underqualified, do not care about the injuries of soldiers, and have a total lack of professionalism.<sup>11</sup> There were also reports of substantial wait times:

With the processes that we have and the waiting times for medical stuff, it was probably four to five months before I could get an MRI. Then it was another month before I could see the specialist

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8 Department of Defence, *Submission 38*, pp. 2-3.

9 Department of Defence, *Submission 38*, p. 5.

10 Mr Brian Freeman, Director, Centori Pty Ltd, *Committee Hansard*, 25 March 2013, p. 9.

11 Name withheld, *Submission 7*, p. 1.

again, and then I had to see another doctor. ... The MRI would have been at least a year after the initial injury, if not longer.<sup>12</sup>

It was not until late 2010 that I could not handle anything anymore. I went into the RAP in Townsville and saw the doctor to see if he could point me in the right direction to start getting fixed up. He told me I had poor abdominal strength and I needed to work on my core strength. He booked me in for an X-ray, but nothing was followed up.<sup>13</sup>

At the moment we are having a bit of trouble because it takes so long to see a doctor and some of us have quite bad injuries.<sup>14</sup>

- 4.19 Defence Families of Australia (DFA) highlighted the importance of provision being made for members to obtain independent medical assessments from specialists of their own choosing.<sup>15</sup>
- 4.20 RADM Walker was aware that there were still some transition issues in that the on-base workforce, particularly in Townsville and Darwin, were still not meeting the Key Performance Indicators (KPI) that Defence had stipulated in the contract. She advised that Defence is working with the contractors to address those issues. RADM Walker stressed that health care is being delivered in a timely fashion for people who need urgent health care.<sup>16</sup>
- 4.21 Defence submitted that for on-base non-urgent medical appointments, of a total 51 facilities, 80 per cent had improved or not changed waiting times following the new contract. For non-urgent on-base mental health appointments, 85 per cent of 40 facilities were improved or unchanged; for non-urgent psychology appointments, 79 per cent of 43 were improved or unchanged; non-urgent physiotherapy appointments, 80 per cent of 40; and likewise for non-urgent on-base dental appointments.<sup>17</sup>
- 4.22 In terms of off-base waiting times, Defence advised that when referring an ADF member to an external specialist, the referring health practitioner is required to identify the referral priority (Routine, Clinically Urgent or Operationally Urgent) and the Service Delivery Priority (Priority 1: Less than 7 days, Priority 2: 7 to 28 days and Priority 3: Greater than 28 days). The Central Appointments Team then books specialist appointments in accordance with the referral and service delivery priority identified by the
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12 Soldier A, *Committee Hansard*, 25 October 2012, pp. 2–3.

13 Soldier B, *Committee Hansard*, 25 October 2012, p. 4; Regimental Aid Post, the unit medical centre.

14 Soldier J, *Committee Hansard*, 26 March 2013, p. 13.

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

16 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 7.

17 Department of Defence, *Submission 38*, p. 4.

referring health practitioner. Defence advised that the average national wait time for an appointment with the following medical specialists booked through the Central Appointments Team is:

- Orthopaedic Surgeon - 16 days (business days);
- Dermatologist - 22 days;
- General Surgeon - 17 days;
- Obstetrician/Gynaecologist - 18 days; and
- Otolaryngologist/Head Neck surgeon - 22 days.<sup>18</sup>

4.23 Defence went on to advise that Joint Health Command does not provide health support in the operational setting. This is the domain of the single Services, however, Joint Health Command supports the generation of ADF operational capability. Joint Health Command provides ADF health personnel with access to training which ensures that they can deliver health care while in the field, air and at sea during operational and training activities or when in the garrison health facilities. This training covers a number of areas including combat first aid, care of battle casualties, emergency/trauma care and mental health care and support.

4.24 Commander Joint Health, in her role as Surgeon General of the ADF, also has technical responsibility for health care in the deployed environment, and exercises this responsibility through the development of policy and doctrine, and management of operational health capability requirements. This work is undertaken with input from the single Services.<sup>19</sup>

4.25 In response to a question on the implications of Defence budgetary reductions, RADM Walker said:

There are no treatment services that are not provided on the basis of any budgetary restrictions. We have never refused anyone treatment.<sup>20</sup>

4.26 Likewise, Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army said to the Committee:

The Chief of Army's very clear. We will support operations and we will support our wounded.<sup>21</sup>

4.27 Finally, Defence advised that they are responsible for the health care of serving members and the provision of all ancillary support services resulting from a health issue. The Department of Veterans' Affairs (DVA)

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18 Department of Defence, *Submission 38*, p. 5.

19 Department of Defence, *Submission 17*, pp. 3-4.

20 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 8.

21 Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, *Committee Hansard*, 19 March 2013, p. 8.

will provide compensation and other support for a work related wound, injury or illness but not health care or rehabilitation until the agreed point of transition from the ADF.<sup>22</sup>

## Reservists

- 4.28 Reservists serving on Continuous Full Time Service (CTFS) are provided with the same level of health services as Permanent Force members. When wounded, injured or suffering an illness resulting from Defence service, health care for that injury or illness will be continued after the Reservist ceases to be on continuous full time service and resumes part-time service.
- 4.29 Reservists serving on other than CFTS contracts receive health care for injury or illness resulting from their Defence service until the transfer of the member into the military compensation system, administered by the DVA, is completed.<sup>23</sup>
- 4.30 DVA advised that a significant sub-group of those with operational service include reservists, with active reservists numbering 21,554 as at May 2011. Twelve per cent of this group had undertaken continuous full time service in the 12 months to May 2011, with a median period of service of 140 days. Sixty per cent had undertaken continuous defence service of five or more consecutive days in the same period, with a median period of service of 28 days.<sup>24</sup>
- 4.31 The Returned and Services League of Australia (RSL) South Australia Branch submitted concerns about the issues confronted by Reservists who, after decompression (the term for a programmed period where members who have returned from operations de-stress in a controlled environment) immediately return to civilian work and tend to be forgotten by the ADF.<sup>25</sup> Likewise Associate Professor Susan Neuhaus CSC expressed concern about the psychological effects of service on Reservists because the visibility of that group diminishes as they leave service and moved back into the civilian community.<sup>26</sup>
- 4.32 One Reservist submitted that they are treated as second class citizens when health issues arise months or years after returning from operations. They argued that in the case of psychological trauma or other injuries, which often take some time to manifest, the ADF wants 'no part' of the

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22 Department of Defence, *Submission 17*, p. 4.

23 Department of Defence, *Submission 17*, p. 3.

24 Department of Veterans' Affairs, *Submission 18*, p. 8.

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

26 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 18.

rehabilitation process except to possibly downgrade the member's medical classification and 'show them the door'.<sup>27</sup>

- 4.33 It was submitted that greater support must be given to Reservists following their return to Australia, particularly those who have deployed individually, without the support of a unit.<sup>28</sup> RADM Walker responded:

We have some concerns about reservists.... If you are a reservist and you have gone back into your civilian occupation ... it is ... about identifying those people and how they access all the support mechanisms that are there. So, we are continuing to look at the reservist population.<sup>29</sup>

## Defence civilians

- 4.34 The Committee also notes that many Defence civilians deploy as reservists and return to work within Defence as veterans, resulting in special management issues. The Committee heard of one instance where 'poor and totally inappropriate people management practises' were displayed while dealing with a reservist's operationally caused post-traumatic stress disorder (PTSD).<sup>30</sup>

## Rehabilitation programs

- 4.35 Defence submitted that there are three complementary programs for the recovery and rehabilitation of ADF personnel and each has a different purpose and scope depending on the clinical, vocational and psycho-social needs of each individual. These are described below.<sup>31</sup>

### ADF Rehabilitation Program

- 4.36 The ADF Rehabilitation Program is delivered by the Garrison Health Organisation and provides an occupational rehabilitation service. This includes the coordination of care through Comcare approved rehabilitation consultants, who are the conduit of information between other support Services, Command, medical and the member.
- 4.37 In addition, the ADF Rehabilitation Program provides rehabilitation assessments, rehabilitation programs and specialist assessments such as

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27 Name withheld, *Submission 16*, p. 2.

28 Name withheld, *Submission 16*, p. 6.

29 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 9 October 2012, p. 3.

30 Name withheld, *Submission 16*, pp. 33-47.

31 Department of Defence, *Submission 17*, pp. 15-16.

home, workplace, daily living activities, functional capacity and vocational assessments. This program also provides for non-clinical aids and appliances.

## Paralympics Sports Program

4.38 The Paralympics Sports Program, through an established relationship with the Australian Paralympic Committee, supports all serving ADF members with acquired disabilities to adopt an active lifestyle, regain their physical fitness and participate in adaptive sport right through to elite Paralympic sport.

## Simpson Assist Program

4.39 Joint Health Command identified a rehabilitation capability gap relating to the overall clinical services for severely injured members and support to their families which resulted in the development of the Simpson Assistance Program. The program will deliver new recovery and rehabilitation services by developing a tailored, integrated and multidisciplinary approach to accelerated rehabilitation for seriously wounded, injured and ill members. Simpson Assistance Program initiatives will contribute to rehabilitation excellence through a focus on:

- a new Intensive Recovery Program to be trialled in Townsville and Holsworthy in 2013;
- new holistic psychosocial member and family support services;
- improved clinical treatment options;
- provision of meaningful engagement options to Defence members on rehabilitation;
- improved coordination of services (case coordination as well as a member's healthcare needs perspective);
- rehabilitation research investment funding; and
- an ADF Rehabilitation Strategy and improved governance and reporting.

## Intensive Recovery Program

4.40 The Intensive Recovery Program is the major clinical effort within the Simpson Assistance Program. The Intensive Recovery Program aims to fill the void between the specialist rehabilitation services available through public/private partners and the general restorative therapies available through Garrison Health.



4.41 The Intensive Recovery Program commenced in February 2013 and is intended to develop a specialist and highly experienced rehabilitation team, and the required equipment and supporting facilities, to provide individually-tailored recovery programs to members with complex circumstances. The team will also provide a specialist advisory and assessment service within the region and nationally. Following a scoping phase, the Intensive Recovery Program will be piloted over 18 months, in Lavarack Barracks (Townsville) and at Holsworthy Barracks (Sydney).

## Support for Wounded, Injured or Ill Program

4.42 In late 2010, a review of practices to support personnel moving to civilian life found that, while the system supporting these personnel was generally good, it was inherently complex and improvements could be made. The aim of the review was to support the development of a seamless and integrated support process for injured or ill ADF personnel.<sup>32</sup>

4.43 An analysis and identification of gaps in the support to ADF wounded, injured or ill personnel resulted in DVA jointly implementing the Support for Wounded, Injured or Ill Program (SWIIP) which is designed to take what is generally acknowledged as a good system and make it better.

4.44 SWIIP aims to ensure the focus is on the member and their family, that complexity involved in obtaining support is reduced, and that any gaps in support are closed.<sup>33</sup> The ADF aims to provide coordinated, transparent and seamless support to individuals during their service and after transition including by:

- Enhancing support for personnel with complex or serious medical conditions who are transitioning to civilian life;
- Improving information sharing between DVA and Defence relating to injury or illness;
- Simplifying processes involved in applying for an acceptance of liability for compensation; and
- Streamlining and simplifying compensation claims handling.<sup>34</sup>

4.45 RSL Victoria submitted that while SWIIP is a very good model, it appears that the partnership between Defence and DVA has 'some way to go' to ensuring the program is delivering best practice service.<sup>35</sup> Similarly, RSL

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32 Department of Veterans' Affairs, *Submission 8*, p. 15.

33 Department of Defence, *Submission 17*, p. 16.

34 Department of Veterans' Affairs, *Submission 8*, p. 16.

35 Returned and Services League of Australia, *Submission 11*, p. 4.

National Headquarters believes that, whilst there have been significant improvements in the management of ADF personnel wounded and injured on operations, they submitted that there were still 'many areas' which were problematical and needed to be addressed.<sup>36</sup>

## Army – Support to Wounded, Injured and Ill Program

- 4.46 Army – Support to Wounded, Injured and Ill Program (A-SWIIP) facilitates the effective management of seriously wounded, injured and ill Army personnel.
- 4.47 Defence submitted that responding to the needs of a seriously wounded, injured or ill member and their family necessitates the coordinated and focussed efforts of the chain of command and supporting agencies to ensure that every member returned to the workplace after an injury or illness contributes to ongoing capability.
- 4.48 The framework of A-SWIIP is intended to ensure that Commanders are able to mobilise and coordinate all the resources required to support their wounded, injured or ill soldiers. Commanders appoint a Unit Welfare Officer as the soldier's primary contact to access local services and oversee the Welfare Board process.
- 4.49 Welfare Boards with multidisciplinary representation are conducted regularly to track progress, coordinate support and identify any issues to be resolved.
- 4.50 Army Member Support Coordinators are regional subject matter experts on casualty management. They provide the member and unit an established point of contact to assist with provision of aids for independent living, access to compensation forms and assistance in meeting travel and accommodation requirements.
- 4.51 The A-SWIIP framework functions to manage seriously wounded, injured or ill soldiers requiring convalescence, hospitalisation and/or significant assistance with activities of daily living.
- 4.52 The three broad levels of management are:
- normal medical management – applies where no medical employment classification (MEC)<sup>37</sup> action is required and supported by usual command arrangements;

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36 Returned and Services League of Australia, *Submission 11*, p. 6.

37 Medical Employment Classification (MEC) - MEC 1: Fully Employable and Deployable, MEC 2: Employable and Deployable with Restrictions, MEC 3: Rehabilitation, MEC 4: Employment Transition, MEC 5: Separation.

- standard rehabilitation – applies to members who are classified as ‘MEC 3’ for periods up to 12 months and managed via Unit Welfare Boards; and
  - extended rehabilitation – applies to members with severe wounds, injury or illness and is managed via Individual Welfare Boards.
- 4.53 Extended rehabilitation is a two year program designed to provide time in which to evaluate the member’s ability to be retained in their previous trade, retrained or transitioned. Options exist for a further three year extended transition period focused on vocational/civil employment skills and education. This phase prepares the member for separation from Army.

### Navy SWIIP initiatives

- 4.54 Navy has stood up similar processes to Army including Member Support Coordination officers. During the initial phase of the wounded or injured member’s treatment a medical employment classification determination is made and this is the authority to administratively post the member to the nearest Navy Personnel Support Unit. Defence advised that currently, the Member Support Coordination officers will be the liaison between the medical facility and Command. The Commanding Officer of the Navy establishment in which the Personnel Support Unit is located has the ultimate responsibility for the health and welfare of the member under their command.
- 4.55 The Member Support Coordination officers will continue in the liaison role between the appointed Joint Health Command Rehabilitation Consultant and the Personnel Support Unit once the member has been discharged from hospital and commences rehabilitation. The Member Support Coordination officers coordinate with the member, the member’s next of kin and the Rehabilitation Consultant to ensure all non-health agency or other authorities’ actions are coordinated to align with the healthcare of the member. The Member Support Coordination officers will ensure that the member or their representative is visited by DVA On Base Advisory Service (OBAS) personnel for the processing of DVA compensation claims. The Member Support Coordination officers ensure that the member’s care and rehabilitation is raised for discussion at the member’s parent unit Command Focus Group. On behalf of Command, the Member Support Coordination officers ensure that periodic case conferences are convened to track the progress of their care and have the member, their representative and other key stakeholders agree to treatment/rehabilitation course of action.

- 4.56 If the member's medical condition indicates that a return to work in their current or alternative employment is likely, a return to work strategy is planned at one or a series of Case Conferences by the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer. In addition to the active clinical rehabilitation of the Navy member, the Rehabilitation Consultant, the Member Support Coordination officers and the Personnel Support Unit Case Officer ensure that the member has 'meaningful engagement' during periods when they are not undergoing actual rehabilitation treatment.
- 4.57 If the member will not be able to return to work in the Navy, a transition timeframe is developed to ensure a strict succession of actions are implemented to ensure the smooth transition of the member. These are coordinated by the Member Support Coordination officers with oversight from the Personnel Support Unit Case Officer. These actions include, but are not limited to resettlement counselling and liaison.

### **Air Force SWIIP initiatives**

- 4.58 Air Force intends to establish a Member Support Coordination Office incorporating the existing Compensation Claims Liaison Officer-AF. It will encompass both compensation claims support and the Member Support Coordinator function. The Member Support Coordination Office will assist commanders with the effective management of members with complex health circumstances and link into the Soldier Recovery Centres where required. This will ensure that all relevant support services are in place for the member. The dual role of the Member Support Coordination Office will also ensure that these members will receive appropriate and prompt compensation assistance.
- 4.59 Air Force is also in the process of establishing Individual Welfare Boards for individual case management of Air Force people. These Boards will be conducted at unit level and will allow a member's commander to consider all aspects of a member's health and wellbeing so that appropriate action is taken to ensure the best outcome for the individual.<sup>38</sup>

### **Physical rehabilitation and medical treatment**

- 4.60 The Committee heard that, generally speaking, the military view physical wounds and certainly combat related injuries as 'a badge of honour'.<sup>39</sup> Of

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38 Department of Defence, *Submission 17*, pp. 16-18.

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

more concern to the Committee is how members who are wounded or injured convalesce and recover. The Committee heard evidence that the opinion of the standard of medical support provided by the ADF can vary from individual to individual. The RSL believes that the overall treatment and support of ADF personnel wounded and injured on operations is managed well by the ADF.<sup>40</sup>

- 4.61 Some individuals reported very positive experiences to the Committee.<sup>41</sup> Others, however, felt their career management and treatment has been appalling<sup>42</sup> and mismanaged:<sup>43</sup>

Unless you are missing a limb – something which they can physically see – you are in the back corner.<sup>44</sup>

- 4.62 Additionally, evidence provided to the Committee suggested that some members are bastardised, receive threats and are accused of malingering while undergoing rehabilitation and discharge. The Committee heard that in some instances the way that injured soldiers are treated is ‘truly disgusting’; and that the system is ‘broken with rampant and unchecked corruption’.<sup>45</sup>

- 4.63 Associate Professor Malcolm Hopwood, Clinical Director of Austin Health’s Psychological Trauma Recovery Service (PTRS) told the Committee that he considers it desirable that individuals who have both physical and mental health difficulties receive integrated physical and mental health care. He gave evidence that rehabilitation care for physical health can be integrated well with mental health care.<sup>46</sup> Go2 Human Performance also highlighted the importance of an ‘integrative’ approach to rehabilitation.<sup>47</sup>

- 4.64 Having interacted with a great number of wounded and injured soldiers while providing adventure training, Mr Freeman ventured the opinion

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40 Returned and Services League of Australia, *Submission 11*, p. 2.

41 Name withheld, *Submission 6*, p. 2.

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

43 Name withheld, *Submission 7*, p. 1.

44 Soldier M, *Committee Hansard*, 26 March 2013, p. 11.

45 Name withheld, *Submission 7*, p. 1.

46 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 2.

47 Go2 Human Performance, *Submission 29*, pp. 2–3.

that a great many veterans with physical wounds also have mental wounds to some degree:

Every Wednesday morning we have sessions with our adventure conditioner. Most of the soldiers in there are suffering from post-traumatic stress, diagnosed or undiagnosed.<sup>48</sup>

## Facilities

- 4.65 The Vietnam Veterans' Association of Australia submitted that, while expanding the availability of dedicated repatriation-specific hospitals and convalescent facilities is not justifiable, the high standard of care set by these types of facilities should be mandated in caring for wounded and injured veterans.<sup>49</sup>
- 4.66 Soldier On submitted that the bulk of the rehabilitation equipment used by recuperating wounded and injured within private hospitals is generally supplied and supported by the hospital or, in many instances, has been bought through private fundraising. Organisations such as Soldier On work to fundraise and provide additional specialised rehabilitation equipment to private hospitals.<sup>50</sup> Professor Leahy told the Committee that Soldier on are investigating putting similar machines in troop concentration areas around Australia.<sup>51</sup>
- 4.67 Sergeant (Sgt) Craig Hansen from 7th Battalion the Royal Australian Regiment told the Committee that the Defence Housing Authority had become very responsive to the needs of wounded and injured members.<sup>52</sup>

## Malingering

- 4.68 The Committee heard some evidence that individuals with real physical injuries are sometimes suspected of malingering, or at least of deliberately letting their mates down. One soldier reported that he was treated like an outcast because he was incapable of doing his job and was rubbished and ostracised by the hierarchy within the unit and treated poorly, he said,

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48 Mr Brian Freeman, Director, Centori Pty Ltd, *Committee Hansard*, 25 March 2013, p. 7.

49 Vietnam Veterans' Association of Australia, *Submission 27*, pp. 3–4.

50 Soldier On, *Submission 15*, p. 4.

51 Professor Peter Leahy, Chairman Soldier On, *Committee Hansard*, 27 November 2012, p. 3.

52 Sgt Craig Hansen, 7th Battalion Royal Australian Regiment, *Committee Hansard*, 8 February 2013, p. 25.

mainly out of ignorance. The Committee heard that the attitude within that particular unit had, however, been dealt with.<sup>53</sup>

There is a stigma in the Army if you are broken: you are a malingerer. It just keeps going. It is more of an old-school thing.<sup>54</sup>

## Equipment issues

4.69 Mr Rod Martin, the Director of Go2 Human Performance, told the Committee that lower back pain and neck pain were the most common presentations to their clinic. He attributed this to the weight of the helmets worn, and equipment carried, by soldiers on operations.<sup>55</sup> Indeed, the Committee heard from several witnesses regarding the weight of equipment that was required to be carried:

I weighed my kit over there – body armour, weapon, and carrying all the equipment stuff that went in for all that. It weighed 51 kilos, which is more than half my body weight, and we did 15- to 20-kilometre patrols with that.<sup>56</sup>

4.70 The Committee heard also, however, that equipment is being continually improved and lightened, and that by 2012 body armour and operational specific equipment ‘changes were quite significant, and they had come a long, long way’ and that while body armour was always going to be relatively heavy, the fit of body armour had been greatly improved.<sup>57</sup>

4.71 One soldier suggested using ‘quad bikes’, or at least smaller tactical vehicles, to carry heavier equipment.<sup>58</sup> The Committee decided that this was beyond the scope of the terms of reference of the Inquiry (as with the issue of Army’s decision to remove berets as standard headwear<sup>59</sup>).

4.72 The Committee heard that ‘blast gauges’ had been issued to soldiers to record blast and shock waves and Mr Simon Bloomer, Executive Officer of Carry On (Victoria) said that it was a significant step forward.<sup>60</sup>

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53 Soldier F, *Committee Hansard*, 25 October 2012, p. 13.

54 Soldier E, *Committee Hansard*, 25 October 2012, p. 13.

55 Mr Rod Martin, Director, Go2 Human Performance, *Committee Hansard*, 25 March 2013, p. 4.

56 Soldier J, *Committee Hansard*, 26 March 2013, p. 2. See also: Soldier M, *Committee Hansard*, 26 March 2013, p. 2; Soldier P, *Committee Hansard*, 26 March 2013, p. 2; and Soldier J, *Committee Hansard*, 26 March 2013, p. 6.

57 Soldier P, *Committee Hansard*, 26 March 2013, p. 2.; Soldier N, *Committee Hansard*, 26 March 2013, p. 3.; Soldier J, *Committee Hansard*, 26 March 2013, p. 5.

58 Soldier N, *Committee Hansard*, 26 March 2013, p. 6.

59 Soldier M, *Committee Hansard*, 26 March 2013, p. 13.

60 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 28.

## Committee comment

4.73 The Committee believe that for the most part there is a general acceptance of legitimate physical and the need for appropriate rehabilitation within the ADF. One soldier commented that:

I have not really experienced any sort of stigmatising because of my injuries. There is always the odd bloke having a joke, 'Ya 'lingerer!' or whatever else. There is always going to be a bit of that, but generally, throughout, I feel everyone has been supportive, from the rank onwards. They acknowledge that I have an injury and that that injury needs time and effort to be rehabilitated to whatever standard I can get it to.<sup>61</sup>

4.74 The Committee is concerned, however, about the general state of garrison health support, particularly given the reports of time taken to receive non-urgent treatment, not just for members wounded or injured on operations, but for all ADF members.

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### Recommendation 5

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

4.75 The Committee notes that Defence is aware of the issue of access to support mechanisms for Reservist post deployment and is nonetheless concerned that Reservist support needs are not being met.

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### Recommendation 6

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

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61 Soldier I, *Committee Hansard*, 25 October 2012, p. 12.



## 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.<sup>1</sup>
- 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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<sup>1</sup> 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.<sup>2</sup>

- 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.<sup>3</sup>
- 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.<sup>4</sup>
- 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.<sup>5</sup>
- 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.<sup>6</sup>

## 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.<sup>7</sup>
- 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.<sup>8</sup>
- 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.<sup>9</sup>
- 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.<sup>10</sup>
- 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.<sup>11</sup>
- 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.<sup>12</sup> 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.<sup>13</sup> 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

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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.<sup>14</sup>

- 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.<sup>15</sup>

## 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.<sup>16</sup> '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.<sup>17</sup>

- 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.<sup>18</sup> 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'.<sup>19</sup>
- 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.<sup>20</sup>
- 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.<sup>21</sup>  
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.<sup>22</sup>
- 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.<sup>23</sup> Professor McFarlane told the Committee that soldiers are trained to ignore physical hardships and fear.<sup>24</sup>
- 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.<sup>25</sup> 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.<sup>26</sup>

- 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.<sup>27</sup> 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.<sup>28</sup>

- 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.’<sup>29</sup>
- 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.<sup>30</sup> 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.<sup>31</sup>

- 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.<sup>32</sup>

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.<sup>33</sup>

- 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.<sup>34</sup> 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.<sup>35</sup>

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.<sup>36</sup>

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.<sup>37</sup> 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.<sup>38</sup>

## 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.<sup>39</sup>

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.<sup>40</sup>
- 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.<sup>41</sup>
- 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 confidentiality 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 policies 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
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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.<sup>42</sup>
- 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.<sup>43</sup>

## 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.<sup>44</sup>
- 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

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

43 Dr Samantha Cromptvoets, *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.<sup>45</sup>

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.<sup>46</sup>

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.<sup>47</sup>

## 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.<sup>48</sup>

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.

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,

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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.<sup>49</sup>

- 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.<sup>50</sup>
- 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.<sup>51</sup>
- 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.<sup>52</sup>

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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.<sup>53</sup>
- 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.<sup>54</sup> 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.<sup>55</sup>

## 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,

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53 RADM Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2011, 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.<sup>56</sup>

- 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.<sup>57</sup>
- 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.<sup>58</sup>
- 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.<sup>59</sup>
- 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.<sup>60</sup>
- 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.<sup>61</sup>
- 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.<sup>62</sup>
- 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.<sup>63</sup>
- 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.<sup>64</sup> 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.<sup>65</sup>
- 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.<sup>66</sup>

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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.<sup>67</sup>

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.<sup>68</sup>

## 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).<sup>69</sup> 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.<sup>70</sup>

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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;<sup>71</sup> 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.<sup>72</sup>
- 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.<sup>73</sup>
- 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.<sup>74</sup>
- 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

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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.<sup>75</sup> 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.<sup>76</sup>

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.<sup>77</sup> 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.<sup>78</sup>

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 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.<sup>79</sup>

- 5.78 Likewise, Legacy agreed that supportive and supported families are an important element to treatment and recovery.<sup>80</sup> General Cantwell made the point that a member's journey to recovery 'affects families, loved ones and mates'.<sup>81</sup>
- 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.<sup>82</sup>
- 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.<sup>83</sup>

## 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.<sup>84</sup>

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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.<sup>85</sup>
- 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.<sup>86</sup> 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.<sup>87</sup>
- 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.<sup>88</sup> This was also applauded by Young Diggers.<sup>89</sup> 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.<sup>90</sup>
- 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.<sup>91</sup> With respect to the military particularly, aspects of psych-education, information on the

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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.<sup>92</sup>

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.<sup>93</sup>

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.<sup>94</sup> 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.<sup>95</sup>

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.<sup>96</sup>

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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.<sup>97</sup>

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.<sup>98</sup> Other non-traditional treatments such as transcendental meditation, trauma release exercises<sup>99</sup>, naturopathy and acupuncture,<sup>100</sup> yoga and Pilates,<sup>101</sup> art therapy and homeopathy have also reportedly had beneficial effects.<sup>102</sup>

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.<sup>103</sup> 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'.<sup>104</sup>

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.<sup>105</sup>

## 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).<sup>106</sup> '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.<sup>107</sup>

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.<sup>108</sup> 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.<sup>109</sup>

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.<sup>110</sup>

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<sup>105</sup> Department of Defence, *Submission 38*, p. 9.

<sup>106</sup> Department of Defence, *Submission 17*, pp. 18–19.

<sup>107</sup> Soldier I, *Committee Hansard*, 25 October 2012, p. 9.

<sup>108</sup> Department of Defence, *Submission 17*, pp. 18–19.

<sup>109</sup> Soldier B, *Committee Hansard*, 25 October 2012, p. 6.

<sup>110</sup> 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.<sup>111</sup> 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.<sup>112</sup>
- 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.<sup>113</sup>
- 5.98 Soldiers in the SRCs believe that many injured personnel that remain with their units would do better in the Centre.<sup>114</sup> 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.<sup>115</sup>
- 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.<sup>116</sup>
- 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.<sup>117</sup>

- 5.101 SRCs are now operating in Townsville, Darwin, Brisbane and Holsworthy in Sydney.<sup>118</sup>

## 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'.<sup>119</sup>

- 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.

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### 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

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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.<sup>120</sup>

- 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 Cromptvoets' 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

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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.**

## Falling Through the Cracks

- 6.1 This chapter considers the three outcomes available to an Australian Defence Force (ADF) member who has been wounded or injured on Operations; a full return to work, transfer specialisation, or discharge. This Chapter also considers the medical classification process, and moves toward the role that the Department of Veterans' Affairs (DVA) plays in the recuperation process post-discharge. It also considers a reassessment of veteran health care eligibility.
- 6.2 The Department of Defence (Defence) submitted that they have a new policy to confirm the Member Support Coordination arrangements. Member Support Coordination is the overall coordination effort required to ensure that a member, whose circumstances meet the definition of complex, is effectively supported throughout their recovery, rehabilitation and either their return to duty or transition from the Australian Defence Force (ADF). Responsibility for the initiation and management of such coordination resides with the member's Commander.<sup>1</sup>

### Return to work

- 6.3 Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, told the Committee that of the then 249 personnel physically wounded in Afghanistan (two from Navy and the rest from Army), 69 per cent had returned to full duties.<sup>2</sup>
- 6.4 Defence submitted that they are committed to ensuring that, for those servicemen and women who become wounded and injured due to their

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<sup>1</sup> Department of Defence, *Submission 17*, p. 19.

<sup>2</sup> Major General (MAJGEN) Angus Campbell DSC AM, Deputy Chief of Army, *Committee Hansard*, 19 March 2013, p. 6.

participation on Defence operations, their recovery, rehabilitation and return to work is a priority.

- 6.5 The increased focus on a recovery-based, return to work approach to rehabilitation in the ADF has seen a significant increase in rehabilitation referrals and rehabilitation programs over the past two years.<sup>3</sup> Air Marshal Mark Binskin AO, Acting Chief of the Defence Force, advised the Committee that Defence has extended the time that wounded, ill and injured personnel can remain on rehabilitation programs with the express intent of retaining them in the ADF.<sup>4</sup>
- 6.6 The Committee received evidence, however, that this has not always been the case. One Defence member, despite consistently requesting rehabilitation back into the workforce, submitted that the ADF was not willing to interpret the progressive nature of the return to work goals and jumped straight to transition out of the ADF, presupposing a negative rehabilitation outcome.<sup>5</sup> Young Diggers, however, submitted that when a member can return to work, the arrangements in general appear reasonable.<sup>6</sup>
- 6.7 The Australian Centre for Post-traumatic Mental Health (ACPMH) highlighted the importance of ensuring a clinically sound and consistent assessment practice. This included integration with general health services noting that it will be critical that the assessment process is ongoing. This would then ensure that assessments retains a focus on maximising rehabilitation outcomes, whether within Defence or through discharge.<sup>7</sup>

## Change of employment

- 6.8 The history of the ADF over many years has shown that personnel who have been wounded or injured may still be able to perform duties that support the more active personnel, such as clerical support, administration of stores, transport and movement control. The Vietnam Veterans' Association of Australia (VVAA) encourage the ADF to provide retraining and employment to wounded and injured veterans no longer

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3 Department of Defence, *Submission 17*, p. 19.

4 Air Marshal (AIRMSHL) Mark Binskin, Acting Chief of the Defence Force (CDF), Department of Defence, *Committee Hansard*, 9 October 2012, p. 1.

5 Name withheld, *Submission 6*, p. 2.

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

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

able to maintain the military skills and knowledge that would otherwise be lost.<sup>8</sup>

- 6.9 Through clinical and occupational rehabilitation services, Defence argues that it is successfully reducing the impact of injury or illness, including mental health conditions, and returning significant numbers of ADF personnel to the workforce.<sup>9</sup> The Chairman of Soldier On, Professor Peter Leahy AC, agreed, making the point that:

As we went to war and we started getting wounded soldiers again, the question was: how do we keep these people? That is where we are at the moment culturally and that is why I applaud what [Lieutenant General] Ken Gillespie and [Lieutenant General] David Morrison are doing: they are keeping their soldiers, they are retraining them and, where they can, they are giving them jobs that they can do.<sup>10</sup>

- 6.10 Major General (MAJGEN) (Retired) John Cantwell AO DSC praised the ADF remarking that 'We have grown up'. He told the Committee that in the past, a medical downgrade had meant automatic discharge. The ADF is now being smarter and trying to retain skills where possible. The result being that there are people with missing limbs working in headquarters or elsewhere:

Why on earth cannot someone who has shown some difficulties emotionally be looked after, given a job that is not so demanding and difficult, with flexible hours, a chance to get some therapy and to stay in uniform for a bit longer.<sup>11</sup>

## Medical Employment Classification Review Board

- 6.11 The Returned and Services League of Australia (RSL) Queensland Branch submitted that there are serious issues with the time taken by the ADF to arrange Medical Employment Classification (MEC) Review Boards (MECRB), which currently take three to four months to convene.
- 6.12 Further, DVA is not always advised of the results of the MECRB decision for the member to separate from the ADF, and therefore their claims for compensation may not be finalised by the time the member separates from the ADF.<sup>12</sup>

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8 Vietnam Veterans' Association of Australia, *Submission 27*, p. 4.

9 Department of Defence, *Submission 17*, p. 19.

10 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 6.

11 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 11.

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

## Discharge and transition

- 6.13 The ADF Rehabilitation Program aims to support a member's return to work in current or different duties or trade or, if this is not possible, they will be rehabilitated, medically separated and supported to transition to the civilian environment.<sup>13</sup> General Cantwell sympathised:
- There is not necessarily a happy ending. Some people will be medically downgraded, and permanently so. They will then be shown the door, unfortunately. I have met people like that. It has broken their hearts.<sup>14</sup>
- 6.14 There was widespread praise of the support provided by Defence and DVA which was described as mostly very good<sup>15</sup> or excellent.<sup>16</sup> The Returned and Services League (RSL) of Australia's South Australian branch believed that the transition from the ADF is well handled by the ADF and the broader RSL organisation believes that there is generally good support provided by DVA and other agencies to ensure that the management of these personnel is efficient and is handled with empathy. However the RSL submitted that this that but should be enhanced.<sup>17</sup>
- 6.15 Notwithstanding the generally positive view of the provided by Defence and DVA, some members submitted that they received no help, counselling, or support from the ADF or DVA while their discharge was being processed.<sup>18</sup> Young Diggers submitted that if the member is going to be discharged, then in some cases the treatment deteriorates as the member gets closer to discharge.<sup>19</sup>
- 6.16 Within the mental health sphere, the ACPMH highlighted the importance of mental health service system clinical roles being clearly demarcated and delineated, and that providers are trained and capable of delivering current evidence-based interventions for the key post-operational mental health problems and disorders. This requires high quality and consistent training models, effective on-going clinical supervision opportunities, and quality assurance mechanisms.<sup>20</sup>

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13 Department of Defence, *Submission 17*, p. 19.

14 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 11.

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

16 Soldier On, *Submission 18*, p. 4.

17 Returned and Services League of Australia, *Submission 11*, p. 2.

18 Name withheld, *Submission 14*, p. 2.

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

20 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 3.



- 6.17 The RSL Western Australian Branch (RSL WA) submitted that entitlements and avenues of appeal need to be better explained and that the RSL should be nominated for this role.<sup>21</sup> The Committee did hear that members were often unaware of their entitlements when they are preparing to discharge.<sup>22</sup>

### Medically unfit for further service

- 6.18 Defence submitted that in an effort to achieve a seamless transition for a member, the various elements of Defence (including Joint Health Command, the three Services, and the Defence Community Organisation (DCO)) and DVA work closely and collaboratively. Defence highlighted the particular importance of early involvement of DVA to ensure that the appropriate arrangements for support post-discharge are understood.<sup>23</sup>
- 6.19 Dr Andrew Khoo, a consultant psychiatrist and the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that care should also be taken to involve the ADF member as much as is reasonably possible in decision making. He noted that the process of resolving the loss of one's career path is easier for an individual if they feel that it was their considered choice, or at least that their difficulties were acknowledged. He submitted that a collaborative process of medical discharge would allay the feelings of abandonment by the Services often reported in recently discharged personnel.<sup>24</sup>
- 6.20 It was pointed out that this perception of rejection contributes in a significant way to anger and guilt, both of which are poor prognostic factors in post-traumatic stress disorder (PTSD), anxiety disorders, mood disorders and substance use.
- 6.21 Defence submitted that ADF members are referred to a regional ADF Transition Centre as soon as it is deemed likely that they may be classified as 'MEC 4' (indicating a member is neither employable nor deployable), and therefore medically separated from the ADF. There are 18 regional ADF Transition Centres that advise and assist members and their families on accessing whole-of-government transition support services, completing Defence separation requirements and accessing separation benefits and entitlements.
- 6.22 As part of the separation preparation, the ADF Transition Centre links members to a variety of services including DVA compensation,

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21 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1.

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

23 Department of Defence, *Submission 17*, p. 19.

24 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Submission 3*, pp. 4-5.

ComSuper, Centrelink, Veterans and Veterans Families Counselling Service (VVCS) and other support services as required.<sup>25</sup>

- 6.23 The Vietnam Veterans' Association of Australia (VVAA) submitted, however, that the medically unfit for further service process (as assessed by their welfare officers, pension officers and advocates) lowers the moral of those personnel affected in that they feel uncertain of their future prospects and that they have no control of their situation. This was said to lead to stress and depression, and in many cases leads to the need for mental health treatment that may not otherwise be required.<sup>26</sup>
- 6.24 Organisations such as Soldier On are assisting with programs linking soldiers to employment in the private sector and have five veterans currently being supported through the recruitment process and being matched to jobs.<sup>27</sup>

### Member support coordination

- 6.25 In a recently released Defence Instruction, Defence has recognised that Defence members who find themselves in complex circumstances that have the potential to restrict, alter or end their service, require effective command-initiated and coordinated support. Such circumstances may result from being wounded or injured on operations, but also equally apply to those diagnosed with a serious illness or suffering some other injury resulting in significant disruption to the member's career and/or personal and family circumstances.
- 6.26 Defence states in the Instruction that it is committed to supporting members, and their families, who find themselves in complex circumstances throughout the member's recovery, rehabilitation and either their return to duty or transition from the ADF. Member support may also involve interaction with a range of service providers internal and external to Defence.<sup>28</sup>
- 6.27 Member Support Coordination is therefore the overall coordination effort required to ensure that a member in complex circumstances is effectively supported throughout their recovery, rehabilitation and either their return to duty or transition from the ADF. The RSL's National Conditions of Service Committee submitted that their only criticism of the new policy is that it places strain on the member's parent unit.<sup>29</sup>

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25 Department of Defence, *Submission 17*, p. 19.

26 Vietnam Veterans' Association of Australia, *Submission 27*, p. 5.

27 Professor Peter Leahy AC, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 4.

28 Department of Defence, *Member Support Coordination*, DI(G) PERS 11-3, 30 January 2013.

29 Returned and Services League of Australia, *Submission 11*, p. 5.

## Health care support transition

- 6.28 Defence advised the Committee that the transition from ADF managed health care and support to that managed by DVA is the responsibility of the relevant single Service. Transition support services provided by the Directorate of National Programs in DCO seek to ensure that members and their families remain well informed, and are encouraged to access educational, financial, rehabilitation, compensation and other government services to facilitate a sound transition.
- 6.29 Informing military members of these transition support services is one of the roles of the regional ADF Transition Centres, where members are required to finalise their administrative arrangements well before their date of separation from the ADF.
- 6.30 Defence submitted that if a member is on a Rehabilitation Program, then prior to separation the Joint Health Command assigned Rehabilitation Consultant ensures the member understands, and has access to, all appropriate services and ensures the member completes all required separation tasks. The ADF Rehabilitation Program provides access to vocational and functional assessments to assist the member in determining appropriate vocational choices post-separation. The Rehabilitation Consultant also works closely with ADF Transition Centres and the DVA to provide information to assist in their determination regarding funding and training requirements.
- 6.31 Defence submitted that it is also committed to providing flexible support for those military members who need to separate at short notice for medical or compassionate reasons. Separating members are provided with effective and appropriate rehabilitation support. The Rehabilitation Consultant liaises with all key stakeholders including the treating doctor, ADF Transition Centres, DVA and DCO to ensure all ongoing services required are in place, including medical assistance and vocational rehabilitation, before their transition to civilian life.
- 6.32 In addition to the regional ADF Transition Centres, information on transition support services is available through a variety of resources. For example, the ADF Transition Handbook is a quick guide to transition information, and support and is available on the internet.
- 6.33 Defence advised the Committee that the DVA On Base Advisory Service (OBAS) was introduced as a Support to Wounded, Injured and Ill Program (SWIIP) initiative in October 2011 at selected bases around Australia. Skilled DVA staff provide information, advice and support to all ADF members on matters relating to the provision of the DVA services and benefits. This service is provided using an agreed visit schedule ranging from five days/week to one or two days per week or month. This ensures

a more streamlined and integrated approach between Defence and the DVA to support wounded, injured or ill ADF members.<sup>30</sup>

6.34 Functions of the DVA On Base Advisory Service are to:

- Provide information and support relating to DVA services and benefits to all ADF personnel who seek assistance;
- Provide support for any current or prospective compensation claims;
- Provide early identification of health, rehabilitation and income support requirements post discharge;
- Liaise with ADF Rehabilitation Program to identify injured personnel and provide appropriate advice and support;
- Liaise with Support Coordinators and other Defence personnel dealing with injured ADF personnel and provide appropriate advice;
- Present and participate in transition management seminars and information sessions and events;
- Where requested, brief ADF personnel and families as part of their pre- and post-deployment briefings;
- Identify and report on trends and issues arising; and
- Develop and maintain relationships with the ADF community, Garrison Health Operational Staff, ADF rehabilitation consultants, Welfare Boards and where necessary, the Defence Transition Cell.<sup>31</sup>

6.35 Defence submitted that the co-location of DVA officers in Joint Health Command health facilities wherever possible has encouraged a collegiate approach between the two Departments ensuring ADF personnel are provided timely and accurate advice. A commitment to the longer term availability of this service has been undertaken and this includes ongoing access to existing infrastructure capability within Defence health facilities.

6.36 The implementation of the DVA OBAS is a significant service delivery enhancement for members of the ADF. Member enquiries to the On Base Advisory Service have steadily increased since the service's inception, and feedback received in relation to the service has reportedly been positive.<sup>32</sup>

6.37 Nevertheless, RSL WA submitted that there is a problem with some members understanding that all aspects of their claims need to be recorded and documented prior to separation, and that considerable support is required in this critical area of activity. RSL WA submitted that

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30 Department of Defence, *Submission 17*, pp. 19–20.

31 Department of Veterans' Affairs, *Submission 18*, p. 14.

32 Department Defence, *Submission 17*, p. 21.

this also needs to be strongly enforced by ADF administrative staff well before separation and not left to the individual to ensure it is done.<sup>33</sup>

## How DVA recognises service-related injuries

- 6.38 DVA submitted that if a serving or ex-serving ADF member has a medical condition (including due to injury or wounding) for reasons related to their service, then he or she may make a claim to DVA for rehabilitation, compensation, care, or a combination of these. DVA assesses claims to establish if there is a connection between an illness, injury or disease and service in the ADF.
- 6.39 DVA submitted that it operates under complex legislative arrangements. Most claims are assessed under one or more of three pieces of legislation:
- the *Veterans' Entitlements Act 1986* (VEA);
  - the *Safety, Rehabilitation and Compensation Act 1988* (SRCA); and
  - the *Military Rehabilitation and Compensation Act 2004* (MRCA).
- 6.40 Claims under VEA or MRCA are assessed using Statements of Principles for any disease, injury or death that could be related to military service, based on sound medical-scientific evidence.
- 6.41 The Repatriation Medical Authority (RMA) consists of a panel of practitioners eminent in fields of medical science whose role is to determine the Statements of Principles which are the factors that 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death. Claims under SRCA are assessed using available medical evidence to support consideration of a disease, injury or illness.
- 6.42 DVA noted that in its 2010-11 Annual Report, the RMA stated that since its inception, it has determined 1,833 Statements of Principles, with 304 particular kinds of injury or disease currently covered by these Statements of Principles.
- 6.43 DVA submitted that if a claim is accepted, then services may include rehabilitation (including vocational assistance), medical treatment (either through reimbursement of medical or care expenses or the use of White or Gold Repatriation Treatment Cards), attendant care, household services, and a range of other benefits – depending upon the particular illness, disease or injury, and its level of severity.
- 6.44 Financial assistance may also be provided for an inability or reduced ability to work, or to recognise the effects of a permanent impairment resulting from a service-related event.<sup>34</sup>

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33 Returned and Services League of Australia WA Branch, *Submission 2*, p. 1.

34 Department of Veterans' Affairs, *Submission 18*, p. 13.

## Stepping Out

- 6.45 DVA's Veterans and Veterans' Families Counselling Service (VVCS) run Stepping Out which is designed to help the transition from the ADF to civilian life. In the program, participants learn about:
- The experience of change as part of life,
  - The transition from the ADF to civilian life,
  - Skills for planning ahead,
  - Skills for staying motivated and adaptable,
  - Expectations, attitudes and troubleshooting, and
  - Maintaining relationships and seeking support.
- 6.46 This voluntary Program is held over two full days and is available across Australia through the fifteen VVCS centres. It is available for all ADF personnel and their partners who are in the process of separation from the ADF or have separated in the last twelve months. Currently serving personnel attending the program are considered to be on duty for the duration of the program, and the program is endorsed by the ADF.<sup>35</sup>
- 6.47 Stepping Out is a voluntary program which was developed for ADF members and their partners who are about to leave the military, or those who have recently done so. DVA has increased marketing of Stepping Out over the last three years, including presenting at all transition seminars and on key ADF bases. This has increased the take-up of the program from 138 in 2008-09 to 333 in 2010-11, and DVA anticipate the uptake continuing to increase.<sup>36</sup>

## Defence/DVA connectivity

- 6.48 DVA submitted that once they have left the military, former personnel who are wounded, injured or ill from operations are a sub-group of veterans with operational service, and all ex-serving personnel. Accordingly, wounded or injured personnel from recent operations share characteristics with their contemporary peers on top of the unique experience of and needs arising from their own injury.
- 6.49 Between 4,000 and 6,000 personnel leave the ADF each year to form the broader group of all ex-serving ADF personnel. This includes those who retire, resign, or who are discharged, including for medical reasons. This
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35 Department of Veterans' Affairs, *Submission 18*, p. 16.

36 Ms Judy Daniel, First Assistant Secretary, Health and Community Services, Department of Veterans' Affairs, *Committee Hansard*, 9 October 2012, p. 9.

- broader group has a range of different service experiences, including peacetime service.
- 6.50 Some personnel with peacetime service only may also become ill or injured as a result of their service, for instance from serious accidents such as the 1996 Black Hawk helicopter accident.<sup>37</sup>
- 6.51 Just over 60 per cent of serving personnel in a recent Defence survey reported that they had been deployed, including 43 per cent reporting they had multiple deployments. As at June 2011, this level of deployment contributed to a count of around 45,000 surviving veterans with operational service from conflicts since 1999.<sup>38</sup>
- 6.52 Defence submits that it ensures ADF members receive a smooth transition to the DVA and other support agencies. This includes a handover from the ADF Rehabilitation Consultant of key information and the Rehabilitation Authority to the DVA.<sup>39</sup> Air Marshal Binskin highlighted the importance of Defence's close cooperation with DVA to ensure the transition from ADF managed care and support to DVA managed care and support is seamless.<sup>40</sup>
- 6.53 Similarly, DVA submitted that it is working closely with the ADF to make the process of discharge from the military into civilian life as smooth as possible, including for those personnel who have sustained wounds or injuries from their service.<sup>41</sup>
- 6.54 For personnel discharging from the military, the move to civilian life (also known as 'transition') can be a stressful process. For those who are wounded, injured or ill there are additional challenges, including accessing care and support that will address their needs appropriately. For instance, an ADF member may also be changing locations and not able to access the same health care or rehabilitation provider. They may also need specialised assistance in re-location and setting up arrangements at home, work, and for transport.<sup>42</sup>

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37 On 12 June 1996, two Black Hawk helicopters collided and crashed at the High Range Training Area near Townsville, resulting in the deaths of 18 Australian Regular Army personnel and injuries to a further 12 personnel.

38 Department of Veterans' Affairs, *Submission 18*, pp. 7-8.

39 Department of Defence, *Submission 17*, p. 20.

40 AIRMSHL Mark Binskin AO, Acting CDF, Department of Defence, *Committee Hansard*, 9 October 2012, pp. 1-2.

41 Department of Veterans' Affairs, *Submission 18*, p. 15.

42 Department of Veterans' Affairs, *Submission 18*, p. 15.

6.55 The Committee repeatedly heard that ensuring that transition arrangements between Defence and DVA for clients are as seamless as possible is a priority for both agencies. DVA quoted Minister Snowdon:

...as well as having responsibility for Veterans, I also have responsibility in the Defence portfolio, for Personnel matters. And what is clear to me that the leadership in both organisations understand the need for collaboration and integration in servicing the needs of our current serving veterans. Particularly those in transition.

And that's why since I took the job, now just on twelve months ago, I have worked hard to bring the Defence and Veterans Departments closer together.<sup>43</sup>

6.56 DVA further submitted that in May 2012, the Secretaries of the DVA and Defence and the CDF agreed key principles for delivering the best possible outcomes for all ADF personnel past and present. These principles set out the responsibilities of both agencies and how they will work together.

6.57 DVA has had a long involvement with helping ADF personnel move into civilian life. They submitted that from 2000 to 2011, the Department under contract from Defence, delivered a Transition Management Service for full-time serving personnel leaving the ADF on medical grounds. Following the cessation of the Department's role in this service, Defence has resumed full responsibility for the service though DVA continues to actively support Defence in the transition process.<sup>44</sup>

## Connectivity perceptions

6.58 Young Diggers submitted that when a member gets a medical discharge their transition through to and including DVA is mostly very good, as is the ongoing health care<sup>45</sup> and the ACPMH submitted that the past decade has witnessed a significant increase in the collaborative relationship between Defence and DVA.<sup>46</sup>

6.59 The Committee received evidence, however, that instances of poor communication between Defence and DVA are occurring and families are not receiving the support they are entitled to require.<sup>47</sup> The RSL Victoria Branch submitted that ensuring communications between Defence and

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43 Returned and Services League of Australia National Congress, 20 September 2011; via Department of Veterans' Affairs, *Submission 18*, p. 15

44 Department of Veterans' Affairs, *Submission 18*, p. 15.

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

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

47 Name withheld, *Submission 2*, p. 2



DVA is vital and that poor communications have meant that treatment, rehabilitation and benefits support to ADF members wounded or seriously injured on operations has 'gone awry'.<sup>48</sup> RSL Queensland's State President, Mr Terence Meehan, advocated improvement in communications between the two Departments:

Expedite the removal of the gulf that has existed between the Department of Defence and the Department of Veterans' Affairs. I am aware that both departments are working very hard to remove it, but it should be a seamless transition so that people who have put their lives on the line for Australia in uniform when they leave the Australian Defence Force and their families should continue to be looked after.<sup>49</sup>

- 6.60 Associate Professor Malcolm Hopwood, Clinical Director of the Austin Health's Psychological Trauma Recovery Service (PTRS), gave evidence that transition management was not as effective as would be desired. PTRS submitted that many individuals leaving the ADF are at risk of having, or have, an established mental health disorder and they are very concerned that there is often a significant delay after leaving the ADF before members receive effective mental health care. PTRS emphasised that it is a shared responsibility between Defence and DVA.<sup>50</sup>
- 6.61 Associate Professor Susan Neuhaus CSC submitted that it would appear that there are also a number of vulnerabilities, particularly for those without established claims, and for those who may not be aware of the linkages of their condition to their service. This is of particular relevance post transition from the ADF.<sup>51</sup>
- 6.62 Defence Families Australia (DFA) suggested that a single identification reference number for Defence personnel that is also used with DVA is needed to address this connectivity issue and recommended that the Personnel Management Keys Solution (PMKeyS) number be used by different agencies, making tracking of an individual simpler.<sup>52</sup>
- 6.63 Defence submitted that they are currently engaging with DVA on the possibility of a single identification (ID) number that works across both Departments. The aim would be to reduce complexity and resolve proof

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48 Returned and Services League of Australia, *Submission 11*, p. 4.

49 Mr Terence Meehan, Queensland State President, Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 6.

50 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, pp. 2, 7.

51 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

52 Defence Families of Australia, *Submission 8*, p. 3; Ms Julie Blackburn, National Convenor, Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 3.

of identification from the start of a member's service by using an existing numbering system rather than introducing an additional number, but this will require further consultation and scoping.

- 6.64 Defence, through Joint Project 2080 Phase 2b.1 a (the Defence Personnel Systems Modernisation (DPSM) project), has proposed to implement a 'Single Person ID' which will be integrated into PMKeys and will improve the ability to track individuals through a variety of relationships within Defence, over time. Defence went on to submitted that they are currently progressing through the design release of this phase of the project and will continue to consult with the DVA and other relevant stakeholders in relation to the possibility of a single identification number.<sup>53</sup>
- 6.65 The Committee feel that implementation of a single identification number is a fundamental and important initiative.

### **Recommendation 11**

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

- 6.66 The Legacy Australia Council submitted that an organisational gap exists in the continuity of care for wounded and injured personnel at the boundary between the Defence and DVA. They submitted that the organisational structure makes very difficult the achievement of unity of effort or to achieve continuity of care and support. A poor transition of a veteran from Defence to DVA complicates and extends their recovery at greater expense to Government and greater distress the veteran and their family.<sup>54</sup> General Cantwell agreed:

I think there is still some difficulty in getting people to engage properly with DVA. I was very well managed by the Department of Veterans Affairs in my own transition, and I am very grateful for that. But I was a General and I probably got special treatment ... Not every young man and young woman that we are discharging from the military has those advantages. There are some gaps in the ability of those people to engage with DVA.<sup>55</sup>

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53 Department of Defence, *Submission 28*, p. 12.

54 Legacy Australia Council, *Submission 12*, p. 3.

55 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 6.

- 6.67 Professor Neuhaus also agreed with this assessment. She told the Committee that despite ‘immense efforts’ by DVA in particular to reach down into the group transitioning out of the ADF, there remain those who fall between the gaps in what is inherently a ‘prismatic and polarised system’. She argued that it is a system where an accepted claim remains the gateway to accessing care.<sup>56</sup>
- 6.68 Austin Health’s PTRS’ principal concern with current arrangements lay in the distance between care arrangements under the auspices of the ADF, and those under the auspices of DVA, with the outcome being that many individuals with operationally related mental health disorders are often without treatment for an extended period after leaving the ADF.<sup>57</sup> Mr Tony Ralph, President of Brisbane Legacy highlighted that:
- Continuity of care is critical, and it is essential for organisational collaboration between all departments ... and the wider community and health sector providers.<sup>58</sup>
- 6.69 Professor Neuhaus submitted that a system integrated across the spectrum of ‘service-to-veteran’ health care would not only provide greater equity of health care for all with service related health conditions, but would enable greater coordination and synergy between multiple care providers and agencies.<sup>59</sup>
- 6.70 Similarly, South Australia’s Veterans’ Health Advisory Council (VHAC) submitted that there is a need to improve local coordination of care and the development of a network of interested mental health professionals. The lack of funding and clear service delivery models has not led to any sustained coordination at the local level, at least in South Australia, they submitted. VHAC recommended the development of an agreed assessment procedure between ADF and DVA services, whether these services are in the private or public sector, and the establishment of coordinated clinical network of service providers who are known to provide evidence based care. Such a network would have components that address those who have first presentation and acute illnesses, as well as the need to establish long term coordinated rehabilitation services.
- 6.71 VHAC submitted that this would be a more effective and efficient delivery system. It would enable better management of demand, given that evidence indicates that interventions are more effective if they are provided early in the course of a disorder. Services were also said to be

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56 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 16.

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

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

59 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

required to address the diverse needs of different genders, and of families. VHAC submitted that there is a need for the future Mental Health Delivery system to be more robust and flexible, but coordinated.<sup>60</sup>

- 6.72 Additionally, DFA highlighted that there are barriers associated with the Privacy Act that reduce continuity of care for ADF members and sharing of information between ADF and DVA, providers and locations.<sup>61</sup>
- 6.73 Professor Sandy McFarlane AO summarised the issue and submitted that mental health services provided to currently serving members and ex-serving personnel should be at the same standards or better than those provided to the Australian community, which was a recommendation of the Dunt Report (the *Review of Mental Health Care in the ADF and Transition through Discharge*).
- 6.74 Professor McFarlane submitted that the nexus between Defence and DVA is even more important for those with mental health disorders than those with physical injuries due to the fact that many individuals with psychiatric injuries arising from being a member of the ADF are discharged without being diagnosed or treated. Professor McFarlane submitted that the Dunt Report has been, and should remain, the key driver to improving mental health care in the ADF. Professor McFarlane submitted that a number of its recommendations have taken on a new urgency with the findings of the 2010 *ADF Mental Health Prevalence and Wellbeing Study*, due to the rates of disorder identified.<sup>62</sup>

## Electronic Health Records

- 6.75 DVA is also working with other agencies to help implement a new Personally Controlled Electronic Health Record (eHealth record). Participation in the eHealth record system is voluntary, with functions available incrementally from July 2012. The eHealth record system is open for consumer registration.
- 6.76 The VVCS information management system is planned to be compatible with the eHealth record system. If they consent to an eHealth record, VVCS clients can have summary information about services they receive from VVCS included in their eHealth record. If the client wishes, this summary information can be made available to other health care providers and their VVCS counsellor can see important information from other service providers.

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60 Veterans' Health Advisory Council, *Submission 33*, pp. 2-6.

61 Defence Families of Australia, *Submission 8*, p. 3.

62 Professor Alexander (Sandy) McFarlane AO, *Submission 30*, pp. 4-6.

- 6.77 The eHealth record will assist in the transition process for current serving ADF personnel, in terms of appropriate care coordination for clients, including for those wounded or injured.
- 6.78 DVA has, since 2006, used an electronic system to manage requests to Defence for service and medical records to streamline the claims process and ensure records are returned to Defence as necessary.<sup>63</sup> MAJGEN Elizabeth Cosson AM CSC, the First Assistant Secretary, Client and Commemorations in the DVA admitted that at the moment, the Defence and DVA Information Technology systems do not communicate ‘as effectively as you would want them to’.<sup>64</sup> Mr Sean Farrelly, the First Assistant Secretary for Rehabilitation and Support with DVA, told the Committee that:
- Systems do need to talk to each other and it is not as straightforward as any of us would like, but we are working hard on it.<sup>65</sup>
- 6.79 DVA is now working with Defence to ensure maximum interoperability with Defence’s Joint eHealth Data and Information System Project. The purpose of this project is to develop and implement an ADF electronic health information system that will link health data from recruitment to discharge. It will generate an electronic health record for ADF personnel that with the client’s consent may be used by health care providers after discharge. This system will also assist with claims for rehabilitation and compensation, enabling DVA staff to have shared access to necessary documentation.<sup>66</sup>

## Retention of records

- 6.80 The RSL National Conditions of Service Committee submitted that Defence medical history files be released only to the member whilst he or she is alive, and that their permission be required for dissemination within the medical fraternity. They submitted that after a member’s death, they should not be publicly released for a term of thirty years.<sup>67</sup>

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63 Department of Veterans’ Affairs, *Submission 18*, p. 21.

64 Major General Elizabeth Cosson AM CSC, First Assistant Secretary, Client and Commemorations, Department of Veterans’ Affairs, *Committee Hansard*, 9 October 2012, p. 12.

65 Mr Sean Farrelly, First Assistant Secretary, Rehabilitation and Support, Department of Veterans’ Affairs, *Committee Hansard*, 9 October 2012, p. 12.

66 Department of Veterans’ Affairs, *Submission 18*, p. 21.

67 Returned and Services League, *Submission 11*, p. 6.

## Memorandum of Understanding

- 6.81 DVA advised that a Memorandum of Understanding (MOU) between DVA and Defence has been developed to better coordinate the delivery of services to veterans, and particularly to create a continuum of service between Defence and DVA to ensure that there is clear responsibility at every point for one department or the other.
- 6.82 The MOU establishes key principles for the cooperative delivery of care and support arrangements for clients and is built on previous agreements between DVA and Defence, incorporating the formal recognition of responsibilities.
- 6.83 MAJGEN Dave Chalmers AO CSC, DVA's First Assistant Secretary for Client and Commemorations, told the Committee that Defence has the lead in caring for and supporting serving members. DVA has the lead in caring for and supporting widows, widowers and dependants, and wounded, injured or ill ex-service members. DVA is also responsible for providing compensation and other support to eligible serving and former members.<sup>68</sup>

## United Minister

- 6.84 The National President of the RSL, Rear Admiral (RADM) (Retired) Ken Doolan AO told the Committee that the RSL had argued for some years that the Minister for Veterans' Affairs and the Minister for Defence Science and Personnel should be the same minister and that the current situation was a 'happy mix'.<sup>69</sup>

## Health care community awareness

- 6.85 Ms Veronica Hancock, the Assistant Secretary for Mental and Social Health in DVA, told the Committee that DVA has several ways of engaging with providers, including some specific online training for community nurses. The training is designed to assist in recognising issues they may be related to an individual's war service. DVA has produced a mental health advice book specifically for general practitioners designed to alert them to the sorts of symptoms and issues that they might be

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68 MAJGEN Dave Chalmers AO CSC, First Assistant Secretary, Client and Commemorations, *Committee Hansard*, 19 March 2013, p. 3.

69 RADM (Rtd) Ken Doolan AO, National President, Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 6.

encountering when dealing with veterans.<sup>70</sup> Dr Graeme Killer, Principal Medical Advisor with the Department of Veterans' Affairs said:

It is all about recognising veterans. As soon as someone comes in you ask them if they have military service, and if they do, a red light should come on.<sup>71</sup>

- 6.86 Professor David Forbes, Director of ACPMH, advised that the Centre worked with general practitioners to encourage them to more consistently ask questions about whether their patients are serving members, or have been serving members of the Defence Force. Professor Forbes told the Committee that ACPMH understands that, in many cases, general medical practitioners may not even recognise that the patients they treat have been members of the ADF, and may not think to relate a medical condition to military service.<sup>72</sup>
- 6.87 Professor Neuhaus submitted that this complexity, and the lack of a unique veteran identifier within Federal, State and Territory Health organisations, creates challenges as it relies on the individual and/or their health professional to make a link between their medical condition and a particular aspect of their service.<sup>73</sup>
- 6.88 Professor Neuhaus told the Committee that the health community does not have a very good concept of what a contemporary veteran looks like, particularly in terms of reservists and women. She said that without a specific identifier or longitudinal tracking system that recognition was missing. She told the Committee that it was routine to identify Aboriginal and Torres Strait Islanders seeking presenting to general practitioners or hospitals for assistance. Medical admission forms routinely have a check-box to identify Aboriginal and Torres Strait Islander heritage; a similar check-box could identify ex/servicemen and veterans to assist healthcare professionals that a patient's medical condition could be associated with service.

## Longitudinal tracking

- 6.89 Professor Forbes highlighted that providing longitudinal tracking or online identification systems can benefit the individual. The alternative would be to contact veterans who leave Defence on a periodic basis to

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70 Ms Veronica Hancock, Assistant Secretary, Mental and Social Health, *Committee Hansard*, 19 March 2013, p. 1.

71 Dr Graeme Killer, Principal Medical Advisor, Department of Veterans' Affairs, *Committee Hansard*, 19 March 2013, p. 2.

72 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 12.

73 Associate Professor Susan Neuhaus CSC, *Submission 31*, p. 3.

remind them about the DVA's existence and the fact that it is there to support them. Such an arrangement would also recognise that sometimes it can take time for physical or psychological issues to present.<sup>74</sup>

- 6.90 Carry On (Victoria) gave evidence that DVA should take up a greater monitoring role for all ex-servicemen, not just veterans.<sup>75</sup>

## Uncontested healthcare liability

- 6.91 The Committee is concerned that a significant difference exists in the treatment of personnel who discharge with a condition that is recognised by DVA, and those who discharge and subsequently develop a service-related condition.
- 6.92 Professor Neuhaus told the Committee that in her opinion, a simpler, more elegant solution to the whole issue of veterans 'falling through the cracks' may be to consider an uncontested healthcare liability for all Australian servicemen and women who have served on active duty.
- 6.93 She submitted that, by accepting the system of comprehensive healthcare for life (which has parallels with the no-fault motor vehicle injury compensation schemes, or a gold card equivalent) there is the opportunity not only to honour the covenant that Australian society has with those who put themselves in harm's way for national interests, but also to 'swathe through layers of entitlement bureaucracy and red tape', and thereby decrease the distress to service personnel and their families of having to establish and verify claims and the accompanying secondary trauma.<sup>76</sup> Dr Khoo agreed:

We have to decrease the barriers to care, because that is the biggest problem in accessing the guys. ... It's a great idea. ... We have to be freer with funding and less suspicious that somebody is talking about something that they might not actually have and are trying to fool the system.

[Have I ever treated a patient that was just trying to get something out of the system?] Yes, but no-one with PTSD ... or any military guys.<sup>77</sup>

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74 Professor David Forbes, Director Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 12.

75 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 22.

76 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 17.

77 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, pp. 14-16.



- 6.94 Professor Neuhaus submitted that this would enable the medical system to prospectively follow the latest cohort of veterans, provide visibility on future health issues and identify any such issues early enough to intervene and thereby avoid the anguish seen following the Vietnam conflict. It would separate the issue of compensation entitlement from the issue of care and enable DVA and other key agencies to focus on the provision of appropriate, timely and responsive healthcare to those who have served, and possibly garner significant national cost savings. She contended that many of those costs are already currently being met by Commonwealth resources through the Medicare system.<sup>78</sup>
- 6.95 The Committee concludes that regardless of any subsequent findings about the circumstances of an injury, veterans being treated by DVA should continue to be treated by DVA given that the costs will be borne by the Commonwealth either way. Furthermore, this would ensure greater continuity of care for veterans.
- 6.96 The Committee agrees that an uncontested healthcare liability model would be appropriate for Australian veterans.

## Recommendation 12

**The Committee recommends that the Government conduct a cost-benefit study of a comprehensive uncontested veteran healthcare liability model and publish the results.**

- 6.97 VHAC submitted that amongst healthcare administrators and providers at a State level, there is little understanding of the fact that members leaving the ADF do not automatically become DVA clients on discharge. The fact that ADF members may leave Defence with health conditions that do not attract a DVA entitlement, as well as having deployment related health conditions, adds to this confusion. The State health system only identifies members with a DVA entitlement rather than ex-ADF members more generally.
- 6.98 This lack of identification of military service means that some ADF members may present with an illness that would attract a DVA entitlement but its relationship to military service has not been identified or assessed as the individual is not recognized as being an ex ADF member.<sup>79</sup>

<sup>78</sup> Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, pp. 17, 20.

<sup>79</sup> Veterans' Health Advisory Council, *Submission 33*, p. 3.

## Medicare

6.99 Defence submitted that equity with provisions of the *Health Insurance Act 1973* underpins the basic entitlement to the range of medical services provided to members of the Permanent Forces. Usually the range of, and ease of access to, health care provided to such members will exceed that available through the public health care system because of the requirement to meet and maintain operational readiness. However, from time to time the Surgeon General Australian Defence Force will issue policies which may exclude or limit the provision of certain medical or dental treatment on the grounds that such treatment is contra-indicated or unnecessary for operational readiness.<sup>80</sup>

## Committee comment

6.100 The Committee agrees with the basic concepts outlined in the Defence White Paper and affirms that it remains critical that:

- The service has adequate staffing with psychiatrists and clinically trained psychologists that augment the primary health care system and that professional development of staff remains a high priority;
- These services need to be provided in the context of an occupational health model that addresses rehabilitation in the ADF context;
- Adjustment programmes need to address the future risk associated with subclinical symptoms;
- The quality and adequacy of services provided to those injured on deployment depends on the standards of care provided within the broader ADF community; and
- An ongoing health surveillance programme identifies emerging trends of physical and mental disorder in those who have deployed and monitors their treatment and that these findings are an initial driver for the introduction of innovative and high quality services.

6.101 The Committee notes Acting CDF's evidence that:

We do not want even one member to fall through the cracks or feel unsupported, but we recognise that at times mistakes will be made. We are committed to learning from these mistakes and ensuring that they are not systemic or repeated in the future. We will work hand in hand with DVA to ensure our system and support mechanisms remain relevant, sensitive to members and

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80 Department of Defence, *Submission 17*, pp. 2-3.

families, and provide the services our members require, both while in service and following the transition from the services.<sup>81</sup>

- 6.102 The Committee is nonetheless concerned about the health and welfare of servicemen and women transitioning out of Defence and agrees that no one must be allowed to 'fall through the cracks'.

### **Recommendation 13**

**The Committee recommends that the departments of Defence and Veterans' Affairs coordinate to clarify the Australian Defence Force/Veteran service delivery models to reduce the complexity, overlaps and gaps in service identified in this report.**

**The Committee further recommends that it be provided with a progress report within six months, and a final implementation report within 12 months.**

- 6.103 The Committee is of the opinion that priority should be given to allowing wounded or injured members to carry on within the broader Defence organisation, if they are unable to stay in uniform.

### **Recommendation 14**

**The Committee recommends that a wounded or injured soldier who wishes to remain in the Defence environment and applies for a position within the Australian Public Service, for which they have the required skills and competencies, be selected preferentially.**

**The Committee further recommends that the Government encourage private sector providers to take a similar approach to the preferential employment of wounded and injured soldiers.**

- 6.104 While there has been some criticism of the lack of information technology connectivity between Defence and DVA, the Committee acknowledges that it is not a simple process to introduce seamlessly connected systems. The Committee is pleased to note that DVA is working with Defence to get early access to health and personnel systems where appropriate.

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81 AIRMSHL Mark Binskin AO, Acting CDF, *Committee Hansard*, 9 October 2012, p. 1.

Nonetheless the Committee is concerned that progress is hampering service provision to veterans.

### **Recommendation 15**

**The Committee recommends that the departments of Defence and Veterans' Affairs expedite the rectification of information technology connectivity issues.**

**The Committee further recommends that it be provided with a progress report within six months, and a final implementation report within 12 months.**

- 6.105 The Committee also agrees that it is imperative that the national health system is able to track identify personnel potentially wounded, injured or harmed by service in the ADF and prompt recognition of the potential for a service-related medical condition.

### **Recommendation 16**

**The Committee recommends that:**

- **as an immediate priority, the national healthcare community include a military/ex-military checkbox as a standard feature on all medical forms; and**
- **the Government commission a longitudinal tracking system to identify the engagement of military/ex-military personnel with the healthcare system.**

## Return from Operations

- 7.1 Chapter seven considers the veteran who returns from operations and, whether knowingly or unknowingly, is carrying physical or mental scars for which they neither seek nor receive treatment. This Chapter also addresses the issue of delayed onset mental health conditions.

### Physical injuries

- 7.2 The Department of Defence (Defence) advised that all members receive a Return to Australia medical brief from medical staff prior to leaving an Area of Operations (AO). Personnel are briefed on the actions required during the post-deployment period and issued with a post-deployment information card.
- 7.3 A post deployment health screen is conducted by a medical officer and includes a targeted physical examination guided by a general health questionnaire. Members are advised on any health eradication regimes at this time (as may be necessary, for example, for malaria or helminths) and provided with the appropriate medication. This regime applies to all personnel, including those injured and undergoing rehabilitation.
- 7.4 A post deployment health assessment is then conducted three months post deployment to review any health issues that may have arisen since the deployment and includes testing for blood borne diseases and audiometry (hearing testing) for those on land based deployments.<sup>1</sup>

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1 Department of Defence, *Submission 17*, p 8.

## Non-reporting of injuries

- 7.5 The Committee heard that it is common for servicemen to not seek treatment for physical injuries:

You would find that most good soldiers would probably be carrying injuries of some sort, especially in Afghanistan, or Iraq when we were there. Everyone gets injured in some form. Most good soldiers will just keep going.<sup>2</sup>

## Post-deployment syndromes

- 7.6 Professor Sandy McFarlane AO submitted that following every major conflict of the 20th century, non-specific physical symptoms have been a common presentation and determining the cause of those symptoms has often led to controversy, such as with Gulf War Syndrome, or the effects of Agent Orange. Professor McFarlane submitted that the possibility of post-deployment syndromes need to be anticipated, and both the question of causation as well as establishing treatment programs to assess and thoroughly treat those affected need to be addressed by research. In this regard, current areas of concern include, but are not necessarily limited to, cancer clusters and mild traumatic brain injury (MTBI).<sup>3</sup>
- 7.7 The Committee shares Professor McFarlane's concerns and recommends that post-deployment syndromes be the subject of further study.

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### **Recommendation 17**

**The Committee recommends that the departments of Defence and Veterans' Affairs sponsor a program of research examining the development of post-deployment syndromes in the current veteran cohort, be it relating to mild traumatic brain injury or some other cause.**

## Psychological issues

- 7.8 Dr Andrew Khoo, a consultant psychiatrist and the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that the *2010 ADF Mental Health Prevalence and Wellbeing Study* carried out on serving ADF personnel found that over a 12 month period, 20% of the

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

3 Professor Alexander (Sandy) McFarlane AO, *Submission 30*, p. 3.

Australian Defence Force (ADF) population suffered from some form of mental health disorder.

- 7.9 Whilst this is a similar rate to the general community, ADF personnel represent a younger, more motivated, male dominated and physically more robust cohort. When the same cohort was asked if they had ever experienced an affective, anxiety or alcohol use disorder, this number increased to over 50 per cent. Combined with the United States (US) figures, these findings show rates of 25-30 per cent of returned soldiers exhibiting significant psychological symptoms (typically a diagnosable mood, anxiety or substance use disorder), Dr Khoo submitted that it would be a reasonable assumption to make that overseas deployment and exposure to trauma increases the incidence of psychological distress and disorder.<sup>4</sup>
- 7.10 The Australian Centre for Post-traumatic Mental Health (ACPMH) submitted that Defence's institution of mental health, suicide prevention and traumatic stress awareness campaigns aimed at improving recognition and reducing stigmatisation and barriers to accessing care has been a critically important initiative.<sup>5</sup>
- 7.11 Professor McFarlane submitted that post-traumatic stress disorder (PTSD) is only one of the common psychiatric syndromes and that depression and substance abuse are, in fact, the more common disorders and that they frequently go undiagnosed.<sup>6</sup>
- 7.12 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health, acknowledged that the issue is not just PTSD but alcohol and drug abuse, depression and broader mental health concerns.<sup>7</sup>

## Pre-deployment screening

- 7.13 Defence, in its submission, affirmed that the Australian Government is committed to protecting the lives and welfare of Defence personnel deployed on operations. A key component of this commitment is the provision of health support to deployed forces. This support ensures that a force deploys at optimal fitness with adequate preventive health measures.

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4 Dr Andrew Khoo, Clinical Director, Toowong Private Hospital (TPH) Group Therapy Day Programs, *Submission 3*, p. 2.

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

6 Professor Alexander (Sandy) McFarlane AO, *Submission 30*, p. 2.

7 Rear Admiral (RADM) Robyn Walker AM, Commander Joint Health, *Committee Hansard*, 19 March 2013, p. 6.

- 7.14 All ADF members who deploy on operations must be assessed as being medically, dentally and particularly psychologically fit for the tasking and are pre briefed on local health threats and appropriate individual health precautionary actions.<sup>8</sup> Commodore (CDRE) Peter Leavy, Director General Navy People told the Committee:

In Navy's case in particular, we started a program last year of pre-briefing sailors involved in Operation Resolute, the border protection operation in the north of Australia, and providing dedicated screening of those who have been involved in the operations to try and identify early potential problems where professional help can be brought in early.

It is very early days; it has only been running for about a year now, but, again, there are positive signs and we are hoping that throughout their careers we will be able to follow much better those people who were involved in potentially traumatic events.<sup>9</sup>

- 7.15 Health threats to Defence members may be operational, environmental, psychological and/or occupational. Operational health threats are those posed to Defence members by weapons systems, which may include non-conventional weapons. Environmental health threats include communicable diseases and environmental hazards. Psychological threats include an assessment of threat to self, exposure to trauma and operational stress. Occupational health threats are those posed to Defence members by their own weapon systems, platforms and/or work environments. Briefs addressing these specific health risks are developed and where possible appropriate measures to mitigate the threats are advised.<sup>10</sup>

### Pre-deployment medical screening

- 7.16 All ADF members' medical employment classifications (MEC) are reviewed between four and eight weeks prior to deployment to ensure that they are fit to deploy and all required vaccinations have been administered. A further check is undertaken within seven days of departure to ensure no additional medical conditions have occurred.<sup>11</sup> Associate Professor Neuhaus CSC told the Committee that she is comfortable that the process is a 'fairly comprehensive and robust system of pre-deployment screening'.<sup>12</sup>

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8 Department of Defence, *Submission 17*, p 4.

9 CDRE Peter Leavy, Director General Navy People, *Committee Hansard*, 9 October 2012, p. 5.

10 Department of Defence, *Submission 17*, p 4.

11 Department of Defence, *Submission 17*, p 4.

12 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 20.



7.17 That said, soldiers who spoke to the Committee said that it was common for individuals to deliberately not report injuries, or that prior injuries were not considered significant:

But it is very broad. There are only limited medical staff to conduct these pre-deployments and a lot of it is just a check sheet. You just sort of go through and mark down. ... [My prior injuries were] not really flagged at any of those pre-deployment medicals prior to going back into theatre.<sup>13</sup>

7.18 'Soldier L' told the Committee that, particularly when it comes to deploying on operations, soldiers will put aside minor medical concerns and 'just deal with it'. He told the Committee that soldiers will often push aside injuries and pain, acknowledging that that is why there are so many medical problems when units return to Australia because by then, the problem has worsened. While not critical of in-theatre medical support, he said that it was also not always immediately available:

A lot of guys do not want to risk getting sent home, either, because a lot of guys do not want to leave their mates.<sup>14</sup>

### Pre-deployment cognitive testing and psychological screening

7.19 For the Middle East Area of Operations baseline cognitive testing (COGSTATE© Sport) is undertaken and is mandatory for all members of the Special Operations Task Group and attached elements, all combat engineers and explosive ordnance device technicians and all mentoring task force personnel engaged in outside-the-wire duties. Defence submitted that COGSTATE© Sport tests reaction times, concentration, memory and decision making and it is employed as a tool to assist clinicians making decisions about when to return a member to duty after a concussive injury (for example, from an improvised explosive device (IED) strike). Baseline testing allows comparisons to be made with a repeat test after a concussive injury.<sup>15</sup> 'Soldier B', who himself had been struck by an improvised explosive device (IED) said:

The whole battle group did the cognitive function tests so that if they hit an IED later that they could compare the results to see if there was any decline.

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13 Soldier A, *Committee Hansard*, 25 October 2012, p. 3.

14 Soldier L, *Committee Hansard*, 26 March 2013, p. 4.

15 Department of Defence, *Submission 17*, p 4.

I had a friend that hit an IED in September. It was pretty down pat for him. ... They had all the cognitive tests to compare it and stuff like that. I think [that the process] has already improved.<sup>16</sup>

- 7.20 Pre-deployment psychological preparation briefs are given and cover topics such as separation, cultural adaptation, operational tempo, fatigue, stress management and homecoming.<sup>17</sup> Major General (MAJGEN) (Retired) John Cantwell AO DSC, the former Commander of Australian troops in the Middle East, emphasised that:

It is almost impossible to prepare anyone for the horror of combat, for the loss of losing your mate, of the distress and revulsion of picking up pieces of another human being. You cannot prepare people for that.<sup>18</sup>

- 7.21 Associate Professor Malcolm Hopwood, the Clinical Director of Austin Health's Psychological Trauma Recovery Service (PTRS) told the Committee that it is possible to identify some general risk factors for the development of disorders like PTSD. He advised that a prior personal history of depression, anxiety, psychiatric disorder or a prior personal history of trauma is a risk factor for the development of a mental health disorder following subsequent trauma. While not definitive, prior screening for susceptibility to a mental health disorder could provide a general predictive capacity for individuals to be employed in a role appropriate to that susceptibility:

There are undoubtedly individuals who possess some of those risk factors for post-traumatic stress disorder who it may not be desirable to deploy overseas because of the risk, but who could function very effectively with other roles that did not involve a high risk of trauma.<sup>19</sup>

- 7.22 Professor David Forbes, the Director of the ACPMH, agreed. He told the Committee that the evidence on screening for entry and screening for risk is not strong and the biggest risk factors in terms of PTSD development are the nature of the trauma, what happens to the individual, and the kind of support they receive in the aftermath of the event. An individual with a significant psychiatric history would be a concern, though that would be identified as part of the existing screening processes.<sup>20</sup>

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16 Soldier B, *Committee Hansard*, 25 October 2012, p. 5.

17 Department of Defence, *Submission 17*, p 4.

18 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 4.

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

20 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 10.

- 7.23 Professor McFarlane told the Committee that while it is extremely difficult to do, risk-screening could be done: 'We have reached a time where you can actually measure people's psychophysiology'. He gave evidence that startle response, brain function and anxiety responses can be measured on currently accessible systems. In the military context, underreporting would be anticipated and it would be necessary to lower cut-off thresholds as a first step in a screening process.<sup>21</sup>

## Post-deployment psychological screening

- 7.24 Professor Hopwood gave further evidence that PTRS would be of the view that screening for mental health disorders prior to overseas deployment is an appropriate thing to do, but difficult to do effectively. PTRS are aware that there are relative risk factors for the development of mental health disorders in the face of trauma such as a prior history of anxiety or depressive disorder, but these are only relative indicators. Therefore, it is not possible to completely screen out people who are at risk and PTRS believe that effective screening for mental health disorders post-deployment is just as critical.<sup>22</sup>
- 7.25 Defence submitted that members returning from operational deployments receive psychological screening both prior to returning to Australia (return to Australia psychological screen - RtAPS), and three to six months following their return (post operation psychological screen - POPS). This applies to all personnel, including those injured and undergoing rehabilitation.
- 7.26 For those personnel requiring further mental health support and treatment, comprehensive counselling and treatment programs are available using a network of Defence mental health providers and external services.<sup>23</sup> The ACPMH submitted that the implementation of the RtAPS/POPS process is a critically important initiative.<sup>24</sup> As with pre-deployment screening, however, in some instances:

We have POP screening currently, but anyone who has ever been through that – I know; I have been through five of them – laughs it off. It is just generic.<sup>25</sup>

- 7.27 Another soldier commented that 'It's a joke'!<sup>26</sup>

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

22 Associate Professor Malcolm Hopwood, Clinical Director, Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 10.

23 Department of Defence, *Submission 17*, p. 8.

24 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 1.

25 Soldier F, *Committee Hansard*, 25 October 2012, p. 14.

7.28 The Committee received evidence of one instance where PTSD symptoms were identified during both RtAPS and POPS but very little coping advice and no treatment was given at that time.<sup>27</sup> In another instance, a member was able to conceal psychological issues and the POPS interview was conducted as a mere formality.<sup>28</sup> General Cantwell's view was that the POPS process is 'not greatly effective' because the interviews are not generally responded to in an open and honest way. Further:

It would be very difficult to have a genuinely effective, intrusive, compulsory assessment scheme for all those thousands of troops that we have rotated through.<sup>29</sup>

7.29 That said, Professor Forbes told the Committee that the RtAPS/POPS process plays an important function in that it communicates a very strong message that the mental health of every service person is important and will be followed up on an individual basis.<sup>30</sup>

7.30 Defence submitted that ADF personnel are not to redeploy on any further operation until such time as any outstanding post deployment health assessments and POPS screening has been undertaken.<sup>31</sup> Austin Health's PTRS highlighted that the risk of exacerbating mental health disorders through further operational deployments is real and poses operational risk beyond the effected individual.<sup>32</sup> Professor Hopwood highlighted that there is a tension in the screening process between the desire of many individuals in the ADF to continue their role within the forces and a concern that, should they be screened as having a mental health problem, they may be viewed differently by their peers and their occupational role may change.<sup>33</sup>

7.31 Defence also stated in the 2013 Defence White Paper that they will continue to enhance their approach to screening, assessment and treatment of mental health concerns, including PTSD.<sup>34</sup>

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26 Soldier E, *Committee Hansard*, 25 October 2012, p. 14.

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

28 Name withheld, *Submission 16*, p. 7.

29 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, pp. 8, 9.

30 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 10.

31 Department of Defence, *Submission 17*, p. 8.

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

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

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

## Self-awareness and resilience training

- 7.32 Further to RtAPS and POPS arrangements, Dr Khoo submitted that all returning troops ought to be provided with a psychological first aid (PFA) session – including psycho-education on human responses to trauma and on basic signs and symptoms.<sup>35</sup> Defence Families of Australia (DFA) also submitted that such a post-deployment process needed to be considered.<sup>36</sup>
- 7.33 Dr Glen Edwards warned that when assisting ADF personnel presenting with emotional or psychological difficulties, the emphasis is often on PTSD. Rather, what is needed is to determine the ability of the individual to understand and process aspects of their treatment.<sup>37</sup>
- 7.34 General Cantwell made a similar point. Not only was he ashamed of how he was feeling, he did not understand what PTSD was when he first started feeling the symptoms.
- 7.35 General Cantwell felt that it was important to involve senior non-commissioned ranks in advertising mental health self-awareness because of their credibility and influence. He advocated for mental health training being a component of the battery of annual compulsory training Defence members are required to attend.<sup>38</sup>
- 7.36 ACPMH, however, submitted that Defence has been among the international leaders in initiatives focused on the development and delivery of training to enhance psychological resilience, which is in the process of being expanded to focus on re-iterating these strategies across a range of points in service life.<sup>39</sup> Director General Navy People told the Committee:
- We have had a fairly robust program of peer group training sessions. In fact, we have annual awareness training across the department to try and break down that stigma we spoke about earlier and also to provide our own people, our peers in particular, the tools to recognise potential mental health issues with the people they live and work with.<sup>40</sup>
- 7.37 Professor Forbes gave evidence that the potential for building resilience is a field that has been developing recently but that the clinical evidence for the worth of resilience building is not yet fully established. He advised

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35 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs *Submission 3*, p. 3; Name withheld, *Submission 5*, p. 3.

36 Defence Families of Australia, *Submission 8*, p. 3.

37 Dr Glen Edwards, *Submission 34*, p. 2.

38 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, pp. 2, 8, 10.

39 Australian Centre for Posttraumatic Mental Health, *Submission 23*, p. 2.

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

that the program Defence had put in place was probably one of the first that was introduced internationally and that it is based on building an individual's capacity to manage some of the stresses associated with operational deployment. He noted that such strategies may not prevent the development of mental health problems but that it will make some difference.<sup>41</sup>

- 7.38 It was also submitted that research needed to be conducted to establish a means to deprogram (and provide ongoing support to) combat personnel on returning from operations.<sup>42</sup> Dr Edwards submitted that for some returned service men and women the war is not over and that for many it has just began. There is a whole process of readjusting from a life changing experience and it is not always a smooth process.<sup>43</sup> 'Soldier E', a veteran of Afghanistan, told the Committee:

There is no heads up or, 'Okay, you possibly might experience this in the future, and when that happens come and see us', or anything like that.<sup>44</sup>

- 7.39 Specific to Special Forces (SF), Defence submitted that since mid-2011, Joint Health Command has worked collaboratively with Special Operations Command on a performance and wellbeing framework to enhance the physical and mental health of SF personnel. This framework acknowledges the potential impact of multiple combat deployments and includes initiatives to build psychological resilience, monitor health and physical performance and provide early interventions for emerging issues.<sup>45</sup>

- 7.40 The Defence White Paper states that the current ADF mental health reform program has developed a range of initiatives to improve mental health awareness which are in place and will help ensure all members of the ADF are aware of the risks associated with mental health issues including PTSD and know how to address this risk.<sup>46</sup>

## Alcohol use in the ADF

- 7.41 The Committee heard that one of the major manifestations of traumatic stress and mental health issues is alcohol and other substance abuse.

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41 Professor David Forbes, Director, Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 9.

42 Name withheld, *Submission 5*, p. 2.

43 Dr Glen Edwards, *Submission 34*, p. 2.

44 Soldier E, *Committee Hansard*, 25 October 2012, p. 14.

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

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

- Defence submitted that they provide funding support to over 130 bars and clubs on bases around Australia, and provide bar services as part of mess facilities. Bars and clubs play an important role in Service culture and ethos.
- 7.42 In 2012, Defence agreed to reforms to reduce and standardise bar opening hours and promote responsible management of bars across Defence. This change is consistent with initiatives being developed under Defence's Pathway to Change Strategy and the complementary ADF Alcohol Management Strategy. Further phases of bar reform, including consistency in bar management and alcohol pricing across Defence bars, will be finalised over the coming months for implementation later in 2013 and in 2014.
- 7.43 Defence submitted that they provide a comprehensive suite of alcohol, tobacco and other drug services to ADF members. This includes mandatory awareness briefs, psycho-education workshops and access to a stepped care approach to appropriate garrison-based interventions in a primary care setting and referral to external specialist treatment and rehabilitation services as required.
- 7.44 Additionally, Defence advised that they are working closely with the DVA in adapting its health promotion initiative, *The Right Mix - Your Health & Alcohol*, to the needs of current serving ADF members. This includes promotion of the recently released smart phone application *On Track with The Right Mix*.<sup>47</sup>
- 7.45 The Australian Drug Foundation has been contracted to assist Defence with the development of the alcohol management strategy and formulation of single Service implementation plans in collaboration with each Service and Joint Health Command. The strategy is informed by and addresses the recommendations arising from the *Independent Review of Alcohol use in the ADF* conducted by Professor Margaret Hamilton in 2011. Implementation of the strategy is intended to strengthen the ADF approach to alcohol management by providing education and information to ADF members about responsible alcohol use; managing the availability and supply of alcohol; providing support and treatment to those who require it; and monitoring and responding to alcohol related incidents.

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47 Department of Defence, *Submission 38*, p. 10.

- 7.46 To support implementation of the strategy, the ADF will implement four initiatives developed with the assistance and expert advice of the Australian Drug Foundation that will enhance the ADF's existing alcohol, tobacco and other drugs service. These include:
- A review of the Defence alcohol policy aligning Defence policy with evidence based national alcohol and other drug policy;
  - An alcohol behaviours expectations statement which outlines the standards expected for responsible use of alcohol in the ADF;
  - A leader's guide to alcohol management which provides guidance to ADF commanders in relation to all aspects of alcohol use in the ADF with a particular focus on prevention and early intervention; and
  - A hospitality management program designed to provide guidelines for Defence in the planning and conduct of events where alcohol will be available.<sup>48</sup>

### Delayed onset mental health issues

- 7.47 There is a concern that there will be a wave of delayed onset PTSD and a likely increase in mental health prevalence rates relating to contemporary operations.<sup>49</sup> General Cantwell, in his compelling appearance before the Committee said:

There is yet to come a very large number of problems associated with PTSD, ... the numbers will grow, and grow exponentially. We have exposed thousands and thousands of young and old Australians to some pretty brutal experiences. Even for those who are not directly involved in combat, there are an ample number of vicarious exposures and experiences. ... So there is a large wave of sadness coming our way, and the system – DVA and Defence – needs to be ready for it. I wonder whether we are.<sup>50</sup>

- 7.48 Professor Neuhaus told the Committee there is likely to be a significant lag, potentially of many years, before the full extent of the psychological injuries alone, are fully appreciated – after every previous conflict there has been a delay in recognising other injuries or illnesses directly related to operational service that were not immediately identified.<sup>51</sup>
- 7.49 The Returned and Services League of Australia (RSL) South Australia Branch submitted that the development of additional support services for

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48 Department of Defence, *Submission 38*, pp. 10–11.

49 Legacy Australia Council, *Submission 12*, p. 5.

50 MAJGEN (Rtd) John Cantwell AO DSC, *Committee Hansard*, 5 February 2013, p. 4.

51 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 16.



veterans who subsequently develop PTSD is critical and currently lacking. RSL SA submitted that many will be captured by the general health system, however this is not appropriate as mental health issues such as PTSD need specialist treatment. Also, some are not captured until their problems are well entrenched and their condition has caused additional social and family problems, or not captured at all.<sup>52</sup>

I have put a lot behind me. I have achieved four tours of Timor in my 25 years, including 1999-2000 in Balibo. I have seen a lot of stuff and have managed to put everything behind me. Everything escalated last year ... the anger built up and the dreams became more reoccurring to the point of having visions of bags of ice – something you take naturally for granted – around Benny Ranaudo on the 27 hours it took to fly him back to Australia.<sup>53</sup>

- 7.50 The Committee heard that PTSD can lie dormant for up to 30 or 40 years.<sup>54</sup> The Committee heard of several cases of delayed onset of PTSD and other mental health issues as a result of military operational service:

Forty years after serving as a conscript in Vietnam, I had a complete breakdown and was diagnosed with delayed onset, chronic PTSD and severe depression. This war caused injury has completely disrupted our lives and taken away my ability to work.<sup>55</sup>

- 7.51 Early identification of mental health issues is of primary importance – Associate Professor Hopwood gave evidence that for disorders like PTSD, once that disorder has been established for three to five years, but possibly as little as two years, the chance of remediating the disorder shrinks dramatically.<sup>56</sup>
- 7.52 Concern was raised that there is not a broad understanding of how many veterans will be affected by their participation in contemporary operations. Professor Peter Leahy AC gave evidence that Soldier On believes the numbers may be in the thousands.<sup>57</sup>
- 7.53 Dr Khoo did not believe that there is a great probability that there will be increased PTSD rates amongst the current veteran cohort. He told the Committee that PTSD rates of major conflicts stay fairly static, with

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

53 Soldier E, *Committee Hansard*, 25 October 2012, p. 8.

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

55 Name withheld, *Submission 5*, p. 1.

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

57 Professor Peter Leahy, Chairman, Soldier On, *Committee Hansard*, 27 November 2012, p. 1.

Vietnam potentially the only outlier where there were slightly increased rates probably due to the reception faced by the soldiers when they returned. He highlighted to the Committee therefore that, noting the lifetime risk following trauma, it can be assumed 15 to 20 per cent of the veterans of recent conflicts may develop PTSD at some point in their lives.<sup>58</sup>

## Suicide

7.54 The Committee heard of soldiers taking their lives. A recent veteran commented that:

I have also known soldiers who have taken their own lives. Some personal friends have taken their own lives because they did not have this kind of help.<sup>59</sup>

7.55 The Department of Veterans' Affairs (DVA), however, do not have precise information on the number of suicides amongst veterans, though they have had 65 claims between 2003 and 2012 in relation to death by suicide attributed to service, from the Second World War to the present day.

## Vietnam comparison

7.56 The Committee heard evidence that there were both similarities and differences between the experiences of Vietnam veterans and those of the current cohort of veterans. Associate Professor Hopwood noted that only a small proportion of younger veterans had 'reconciled with the old blokes'.<sup>60</sup> A 25-year ADF veteran whose career includes a tour in Afghanistan and four in East Timor told the Committee:

I had the misfortune of seeing it all with my father, a Vietnam vet also in the infantry. I always promised I would never go down that road, although it is my last year as a result of the injuries and everything which have brought it all out.<sup>61</sup>

7.57 Dr Glen Edwards, in his book *Beyond Dark Clouds*, documented his longitudinal record of the psychosocial effects of Vietnam veterans and their families, detailing the stories of twenty veterans, their spouses and children based on two separate sets of interviews conducted in 1986 and 2006, spanning two generations and three countries. All individuals interviewed spoke candidly, highlighting the struggles they face in trying

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58 Dr Andrew Khoo, Clinical Director, TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, p. 16.

59 Soldier F, *Committee Hansard*, 25 October 2012, p. 10.

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

61 Soldier F, *Committee Hansard*, 25 October 2012, p. 15.

to understand and make sense of events that have impacted their lives, often in unexpected and traumatic ways. He submitted that many continue to suffer emotionally, psychologically and physically from their service often in silence or behind closed doors.<sup>62</sup> Professor McFarlane identified the issue:

It is the invisible wounds that are the ones that are most easily forgotten. This was very clearly the case after Vietnam. I think that what we have got to do is make sure that we do not make those same mistakes again.<sup>63</sup>

### Pre/Post-deployment support of families

- 7.58 Defence advised that the ADF is committed to ensuring family members of those ADF personnel wounded or injured on operations are supported through the period from wounding or injury, acute treatment and rehabilitation to return to work or transition from the Service. The ADF and Defence Support Group (DSG) are attuned to the requirements for family-sensitive health care delivery and a number of supporting systems and programs have been or are being implemented to further address the needs of the family.<sup>64</sup>
- 7.59 The Returned and Services League of Australia WA Branch (RSL WA) submitted that families should, like the service member, also receive pre-and/or post-deployment training, if only to be made aware that the person who returns to them after deployment may not be the same person that joined the ADF.<sup>65</sup> DFA also highlighted that this is a common concern with families.<sup>66</sup>
- 7.60 General Cantwell told the Committee that he had not seen anyone brief families on what could be expected when their serviceman returned from operations and felt that such information needed to be provided. He was concerned that spouses and families are vulnerable for a variety of reasons and that their vulnerability could be 'exacerbated by ignorance'.<sup>67</sup>

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62 Dr Glen Edwards, *Submission 32*, pp. 4–5.

63 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 1.

64 Department of Defence, *Submission 17*, p. 8.

65 Returned and Services League of Australia WA Branch Incorporated, *Submission 4*, p. 1.

66 Defence Families of Australia, *Submission 8*, p. 2; Ms Julie Blackburn, National Convenor, Defence Families of Australia, *Committee Hansard*, 12 March 2013, p. 1.

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

## Defence White Paper 2013

7.61 The Committee notes that in the Defence White Paper 2013, the Government announced that it has decided to provide an additional \$25.3 million for enhanced mental health programs including:

- Extending the Veterans and Veterans Families Counselling Service (VVCS) coverage to a number of current and former personnel not currently eligible (that is, border protection personnel, disaster zone personnel, personnel involved in training accidents, ADF members medically discharged and submariners); partners and dependant children up to the age of 26 of these high risk peacetime groups; and families of veterans killed in operational service;
- Extending mental health non-liability health cover to include access for former ADF members with three years continuous peacetime service after 1994 and expansion of current conditions of PTSD, depression and other anxiety disorders to also include alcohol and substance misuse disorders for veterans;
- Implementing a post discharge GP health assessment, using a specially developed screening tool, for former ADF members, including regular and reserve forces;
- Additional funding for the Defence resilience platform, LifeSMART (Stress Management and Resilience Training) for veterans and families. Additional modules may include anger management, substance misuse, depression, anxiety, grief and loss;
- Developing and maintaining a Peer-to-Peer Support program to support recovery of veterans with a mental health condition by providing a non-clinical support network;
- Additional funding for improving processing time for compensation claims by veterans and current serving personnel; and
- Additional assistance for veterans and current serving personnel making claims for injury.<sup>68</sup>

## Committee comment

7.62 The Committee applauds the additional funds announced in the *Defence White Paper 2013* to enhance mental health programs.

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68 Prime Minister, Minister for Defence and Minister for Defence Science and Personnel, *Joint Media Release – 2013 Defence White Paper: Support to ADF Personnel*, 3 May 2013.

- 7.63 On the balance of evidence, the Committee does not, at this stage, advocate employment-related pre-screening of individuals for susceptibility to PTSD but certainly commends current psychological pre-deployment processes and the adoption of pre-deployment cognitive testing. The Committee is, however, concerned at the rigour of health checks, both prior to, and post, deployment.
- 7.64 The Committee agrees that returning troops ought to be provided with Psychological First Aid (PFA) as necessary in order to equip them with the tools to identify trauma-related mental health issues and seek appropriate assistance.
- 7.65 With respect to mental health and PTSD rates in the current veteran cohort, the Committee accepts the evidence that it is unlikely that there will be increased mental illness rates for recent veterans. The Committee notes, however, the evidence that it can be assumed that up to 20 per cent of the veterans of recent conflicts may get PTSD at some point in their lives. The Committee also notes that as many as 50 per cent of servicemen or women can expect to have some form of mental health disorder in their life. The Committee therefore highlights to Defence, DVA and the broader health service provider community that there are at least 45,000 veterans with operational service from conflicts since 1999.
- 7.66 The Committee notes the *Review of Mental Health Care in the ADF and Transition through Discharge* (The Dunt Report) concluded that the prevalence of suicide in the veteran community was not easy to determine.<sup>69</sup> The Committee is very concerned, however, at the lack of data and research regarding suicide rates in the veteran serviceman/ex-serviceman community and recommends that this be quantified.
- 7.67 The Committee was surprised to hear that not only did some families not receive pre-deployment briefings, but that there was not a routine process in place for families to be contacted by the Defence Community Organisation (DCO), or another similar agency, to check on their wellbeing while a member is deployed.<sup>70</sup>
- 7.68 The Committee heard evidence that during pre- and post-deployment health checks, physical injuries to ADF members are not diagnosed due to either the cursory nature of the check, or the member's desire to hide the injury in order to deploy. The Committee is therefore concerned at the thoroughness of these health checks.

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69 Ms Judy Daniel, First Assistant Secretary, Health and Community Services, *Committee Hansard*, 19 March 2013, p. 3.

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

**Recommendation 18**

The Committee recommends that the Department of Defence review the adequacy and rigour of pre- and post- deployment health checks.

**Recommendation 19**

The Committee recommends that the Department of Defence provide all troops returning from operations, including non-warlike operations, targeted psychological first aid and post-deployment psycho-education which should include:

- Education on human responses to trauma;
- Identification of basic signs and symptoms of mental health conditions; and
- Advice on assistance options.

**Recommendation 20**

The Committee recommends that the departments of Defence and Veterans' Affairs conduct an assessment of suicide rates in the military/ex-military community as a priority.

**Recommendation 21**

The Committee recommends that the departments of Defence and Veterans' Affairs establish strategic research priorities to address suicide attributable to defence service.

**Recommendation 22**

The Committee recommends that the Department of Defence establish formal, Defence-wide pre- and post-deployment training for service families, and a periodic contact program for the families of deployed members.

## Veterans Affairs

- 8.1 Chapter eight considers the role of the Department of Veterans' Affairs (DVA) in the care of wounded and injured veterans, and considers some of the issues of DVA's service model and veteran care more broadly. It examines DVA's claims and compensation process, identifies the current claimant cohort and the long term support infrastructure and case management arrangements that DVA has in place to support veterans of recent conflicts.

### Department of Veterans' Affairs

- 8.2 DVA submitted that following a long period of predominantly peacetime service, the Australian Defence Force (ADF) has undertaken a range of extensive and intensive operations since 1999. This has seen a significant numbers of soldiers, sailors and airmen and women deploy on operations, exposing permanent and reserve force ADF personnel to the risk of wounding and injury. With advances in medicine and rehabilitation, both the ADF and DVA have developed considerable experience and strong systems for delivering care to, and supporting the recovery of, ADF personnel wounded or injured on operations. For those with serious wounds and injuries, ongoing care and support may be required over their lifetime.<sup>1</sup> Major General (MAJGEN) (Retired) Elizabeth Cosson AM CSC, DVA's First Assistant Secretary Client and Commemorations, told the Committee:

Over the course of its 94 years of operation, DVA has developed a strong and proud history supporting men and women who have

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<sup>1</sup> Department of Veterans' Affairs, *Submission 18*, p. 3.

offered service to our nation, and the families who have made sacrifices to support them.<sup>2</sup>

- 8.3 It was submitted that veterans from recent deployments are a diverse group with different perspectives and service delivery expectations to veterans from earlier conflicts. The challenge facing DVA is ensuring that it meets the needs of all those entitled to its services – those who have been with them for many years, those who are accessing their services for the first time today, and those who will access their services into the future. DVA submitted that its range of clients includes veterans and war widows aged over one hundred years old, to children as young as one year old. DVA accepted that it has an ongoing role in the care and support for all of these clients.<sup>3</sup>
- 8.4 DVA claimed to have invested significantly in its understanding of the characteristics of the contemporary cohort of veterans, including those who have been wounded or injured. This understanding was said to be helping DVA develop and transform its service delivery models for this cohort. A priority for the Department's applied research program is younger veterans, and veterans transitioning out of conflict zones and into civilian life.<sup>4</sup>
- 8.5 Ms Judy Daniel, DVA's First Assistant Secretary for Health and Community Services, gave evidence that they believe they now have a strong understanding of the needs of the different cohorts, and particularly the contemporary cohorts who have seen service over the last decade of deployments.<sup>5</sup>

## DVA's role

- 8.6 DVA's submission to the Inquiry highlighted that the Department is a major national purchaser and provider of health and community care services worth around \$5.5 billion a year. DVA uses this purchasing power to ensure that all clients, including the wounded or injured, are able to access health and care services in each state and territory. This health care is provided by both the public and private sectors and across the spectrum of service delivery from hospital inpatient and community care services, to primary care in general practice settings.

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2 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

3 Department of Veterans' Affairs, *Submission 18*, p. 3.

4 Department of Veterans' Affairs, *Submission 18*, p. 7.

5 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 9 October 2012, p. 9.



- 8.7 DVA purchases healthcare services over the course of a client's lifetime after discharge, including through periods of acute illness. Services include:
- General medical consultations that provide access specialist medical and dental services;
  - A range of allied health services such as physiotherapy and psychology services;
  - Rehabilitation, including psychosocial rehabilitation;
  - Hospital services in both public and private sectors, including inpatient and outpatient services;
  - Pharmaceutical benefits that provide access to an array of pharmaceuticals and wound dressings;
  - Home care services designed to assist those veterans and war widows or widowers who wish to continue living at home, but who need a small amount of practical help. Services include domestic assistance, personal care, respite care, and safety-related home and garden maintenance;
  - Community nursing services to meet an entitled person's assessed clinical and/or personal care needs in their own home;
  - Counselling services including through the Veterans and Veterans Families Counselling Service (VVCS); and
  - Other services such as transport, including the transport of a carer or attendant where medically necessary.<sup>6</sup>

### DVA's service model

- 8.8 DVA submitted that in 2010, the Department established a program to develop new service models, in order to respond to the changing needs and expectations of the contemporary veteran cohort. This program has implemented a new service model for widow/ers and dependants of contemporary veterans, providing a primary point of contact to help dependants access DVA entitlements and support from other agencies.
- 8.9 Another new service model is in the early stages of development and will assist contemporary ADF members and veterans who have been wounded or injured in service and who have complex and/or multiple needs. The model will respond to different levels of complexity in care, and work with the ADF member support framework to ensure the effective management of transition into civilian life and ongoing support. As well

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<sup>6</sup> Department of Veterans' Affairs, *Submission 18*, p. 20.

as meeting the needs of those wounded or injured on operations, the model is also for those who become injured or ill from peacetime service.

- 8.10 Wounded and injured contemporary veterans were consulted in the development of the model. A practitioner workshop has also been held with ex-service organisations that advocate on behalf of veterans for claims and appeals, and Defence organisations.
- 8.11 DVA submitted that other activities to support the development of this new model include:
- Simplifying how information is provided to clients about entitlements and DVA services,
  - Improving the process of notifying DVA of wounded/injured personnel,
  - Clarifying roles and responsibilities of all involved in supporting the wounded/injured member and their family, and
  - Ensuring DVA's client contact model provides appropriate levels of support to the client and his or her family.<sup>7</sup>

## DVA's client expectations

- 8.12 It was submitted that DVA surveyed the veteran and ex-service communities to help the Department understand what it does well, where things can be improved, and how services might be adapted to meet new and emerging needs. This provided them with client expectations about how DVA service delivery should be structured:
- Person-centred. The seriously wounded/injured veteran should be at the centre of planning and support that is then organised to assist the person to achieve their maximum level of independence and autonomy. This means simplifying their experience with DVA, and offering flexibility and responsiveness to their unique situation with a view to self-sufficiency. It also means placing decision-making with the person, to determine their own life direction and working with providers to assist with the achievement of identified and agreed goals.
  - A proactive approach to the provision of support. The framework for the provision of support should be grounded in the notion that the DVA system takes the initiative for support in consultation with the seriously wounded/injured veteran and their family. This would range from early claim acceptance and pre-completed paperwork at the hospital bedside, identifying and coordinating the type of support and assistance they need. This could include offering equipment packages

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7 Department of Veterans' Affairs, *Submission 18*, p. 21.

matched to the person's disability and needs through to pre-emptive renewal of domestic support services as appropriate.

- Valuing family relationships. The needs of families and the support of family relationships should be considered in everything that is done in terms of care and support. Feedback suggests that the involvement of the spouse or partner is preferred in discussions about the treatment or other needs of wounded or injured personnel.
- Single point of contact. DVA should have a designated person who is the primary contact point for the seriously wounded/injured veteran. This could be someone in a case management or case coordination role.
- Defence/DVA partnership. Roles and responsibilities of the two agencies should be clearly identified and made explicit to all stakeholders at the outset, with a team approach taken to the planning of support on a person-centred basis.<sup>8</sup>

## Claims process

- 8.13 DVA submitted that it is transforming its practices in how it recognises service-related injuries. They are doing this in response to emerging needs from the contemporary cohort and to provide a more flexible, simple and comprehensive process for recognising service-related injury. This includes when and how claims may be made, so it is more flexible and simple for clients. DVA has also assumed a more visible and proactive presence in the ADF, with DVA officers having an on-base presence and providing information to ADF personnel while they are serving.
- 8.14 Up until recently, DVA usually received and assessed claims for service-related injuries either as personnel were discharging from the ADF, or after they had discharged. This had been considered consistent with the responsibilities of DVA for meeting the needs of veterans once they have left the ADF. Over time, with the addition of new legislative arrangements, personnel have also needed to make claims under a specific piece of legislation, and some have needed to make multiple claims under different legislative arrangements.
- 8.15 The knowledge and evidence about the effects of military service has developed over time. DVA submitted that this cumulative knowledge and experience will benefit the current and future group of ex-serving

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8 Department of Veterans' Affairs, *Submission 18*, p. 11.

men and women, including those who have sustained wounds or injuries from recent operations.<sup>9</sup>

## When claims may be made

- 8.16 DVA has been working with the ADF to inform and encourage personnel to lodge claims for service related injuries closer to the time of wounding or injury. This enables these injuries to be recognised by DVA at the earliest opportunity. DVA submitted that this may occur while the member is still serving in the ADF, even if they are not currently receiving treatment for the condition and that this is important because:
- ADF personnel are able to provide information regarding the claim about their condition closer to the time when the event or events causing the condition occurred – which subsequently assists DVA investigate the circumstances which led to the injury or disease;
  - It helps DVA to identify health, rehabilitation and compensation needs early, which helps with better health outcomes for DVA’s clients and long term management of the accepted condition; and
  - It may also allow DVA to pay compensation for service-related injuries if appropriate in a timelier manner (including if the ADF member is still serving).
- 8.17 DVA submitted that its updated model does not prevent personnel lodging claims at a later stage if they choose or need to do so. Personnel can still lodge claims as they are discharging or after discharge. DVA acknowledged that for some conditions, symptoms may only become apparent after many years.
- 8.18 Finally, DVA submitted that the aim is to provide more flexibility to serving and ex-serving personnel as to when they are able to lodge a claim.<sup>10</sup>

## How claims may be made

- 8.19 DVA submitted that since 2004 its claim process has been mainly structured around three acts, with the passage of the *Military Rehabilitation and Compensation Act 2004* (MCRA) which joined the *Veterans Entitlement Act 1986* (VEA) and the *Safety, Rehabilitation and Compensation Act 1988* (SRCA).
- 8.20 DVA is now moving towards a single claim process rather than separate claims under different pieces of legislation. This will be for claims for

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9 Department of Veterans’ Affairs, *Submission 18*, p. 12

10 Department of Veterans’ Affairs, *Submission 18*, p. 12.

DVA to accept a condition as service-related, or for claiming reassessment for a previously accepted condition. Claims will be considered under all relevant legislation to ensure clients have access to the full range of benefits for which they are eligible.

- 8.21 The single claim process will be based upon electronic processing. This will help ensure clients are kept informed throughout the claim process and electronic file management will make service and medical records more accessible to any DVA claims assessor working on entitlements for a client. The feedback received from ex-service representatives and departmental staff following a trial was said to show that a single claim form is far less complex for clients.<sup>11</sup>

### Pro-active support for making claims

- 8.22 DVA submitted that it continues to work with the ADF to ensure it receives early notification of when personnel are wounded, ill or injured and the specific needs the individual, with the ADF member's consent. This includes contact with different areas of the ADF, including the Defence Community Organisation (DCO), the ADF Rehabilitation Program, commanding officers or a Defence Welfare Board.
- 8.23 As discussed earlier, DVA has also introduced the On Base Advisory Service which places specially trained DVA staff at over 35 Defence bases on either a full or part-time basis. This on base presence assists serving and discharging ADF personnel find out about services including rehabilitation, compensation, health services, and support, as well as encouraging the early lodgement of any claims.<sup>12</sup> General Cosson told the Committee:

We now have a more visible and proactive presence on ADF bases. We are also working closely with the ADF to make the process of discharge from military into civilian life as smooth as possible, including for those personnel who have sustained wounds or injuries from their service. With Defence we have a strong commitment to working together, and with this in mind, DVA is focused on providing the right support through rehabilitation and timely access to services and benefits.<sup>13</sup>

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11 Department of Veterans' Affairs, *Submission 18*, pp. 13-14.

12 Department of Veterans' Affairs, *Submission 18*, p. 14.

13 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

## Veterans' reactions to DVA services

8.24 Veterans vary in their assessment of DVA services. It was submitted that the support and interactions with DVA can be very positive<sup>14</sup> and that if your problem is accepted the care is excellent.<sup>15</sup>

8.25 The Committee received evidence, however, that the image of DVA with some veterans and the veteran support community was often far from positive. The Committee received evidence that:

- In at least one instance, there was no DVA support in Townsville and the member in question was managed through Brisbane. The submission highlighted the importance of personal contact in setting a rapport;<sup>16</sup>
- The process is complex, opaque and stressful and in many cases there were problems that appeared to be due to errors or omissions made by the advocate;<sup>17</sup>
- The process of recognition by the DVA of an individual's psychiatric diagnosis is for many ex-servicemen/women a gruelling, prolonged, invalidating and dehumanizing experience that complicates, aggravates and perpetuates the pre-existing psychological distress suffered by veterans and their families;<sup>18</sup>
- DVA is viewed by 'a lot' of ADF members as a hindrance to their claims being approved, and are therefore reluctant to discuss personal matters with DVA;<sup>19</sup>
- Many veterans become disillusioned and give up [making claims] in disgust, feeling further alienated by politicians and bureaucrats;<sup>20</sup>
- DVA are a disgrace, as is the entire compensation system and that DVA will use any excuse they can find to not pay a fair and correct compensation amount;<sup>21</sup>
- If you need to get more conditions accepted it can be hard to wait to go through the DVA claims system and jump all the hoops;<sup>22</sup>

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14 Name withheld, *Submission 6*, p. 2.

15 Name withheld, *Submission 14*, p. 2.

16 Name withheld, *Submission 2*, p. 2.

17 Name withheld, *Submission 5*, pp. 1, 7.

18 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Submission 3*, p. 5

19 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1.

20 Name withheld, *Submission 5*, p. 7.

21 Name withheld, *Submission 9*, pp. 1-2.

22 Name withheld, *Submission 14*, p. 2.

- DVA operates like an insurance company, works at a snail's pace with no accountability for slow or non-response to claims, is adversarial and quite often incompetent in its administration;<sup>23</sup>
  - There is pain, anguish and secondary trauma related to the difficulties and the frustrations in trying to navigate a complex, often bureaucratic, fragmented and entitlements-driven healthcare system;<sup>24</sup> and
  - There are 'significant problems' with the DVA assessment process, that DVA are not forthcoming in providing feedback, that the basic DVA framework is not geared to providing adequate support to the widening profile of veterans, and that on base advisors are 'scarce and hard to communicate with'.<sup>25</sup>
- 8.26 Carry On (Victoria) submitted that experiences such as these results in veterans distrusting in DVA and 'all too often' support organisations are approached by veterans who have not been in touch with DVA at a time when they should be.<sup>26</sup> The Executive Officer of Carry On, Mr Simon Bloomer, said they would like to see DVA have a more flexible case management process and be able to identify an individual's needs, and whether they need more active case management or not.<sup>27</sup>
- 8.27 Defence Families of Australia (DFA) submitted that income assessments following wounding or injuries sustained during operations should be based on the members' own losses in earning capacity, and that the income of a spouse should not be included when assessing pensions.<sup>28</sup>
- 8.28 DVA responded to these concerns by acknowledging that the system is not perfect but insisted that it is getting better. DVA stressed to the Committee, however, that there is no evidence for claims of a steadily increasing proportion of claims proceeding to the Veterans' Review Board (VRB) or the Administrative Appeals Tribunal:
- The underlying rate at which DVA accept primary claims has not changed a great deal for post-traumatic stress disorder, depression or alcohol abuse, and similarly, the proportion of primary claims decisions that go to the VRB do not show significant differences overall over the last three years.<sup>29</sup>

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23 Name withheld, *Submission 16*, p. 2.

24 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 16.

25 Name withheld, *Submission 40*, pp. 1-2.

26 Carry On (Victoria), *Submission 10*, p. 1.

27 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 22.

28 Defence Families of Australia, *Submission 8*, p. 3.

29 Mr Sean Farrelly, First Assistant Secretary Rehabilitation and Support, *Committee Hansard*, 9 October 2012, p. 10.

- 8.29 Dr Andrew Khoo, a consultant psychiatrist and the Director of Group Therapy Day Programs at Toowong Private Hospital (TPH), submitted that DVA had made some progress towards alleviating the problems with the DVA compensation process. This had included increasing numbers of DVA delegates/case managers and reducing their case loads, and providing training including guidance on common veteran psychological problems, typical veteran presentations and communication skills.<sup>30</sup>

## Claims paperwork

- 8.30 The Committee received evidence that the legalities of making claims requires that injured veterans are frequently forced to seek legal advice adding stress and cost to the process and that the volume of information provided by DVA leaves individuals confused about their post-transition financial prospects.<sup>31</sup> Mr Michael (Baron) von Berg MC of the Veterans' Advisory Council of South Australia told the Committee:

The digger is a pretty simple sort of individual – a wonderful individual, but simple – who does not really know how the system works. Therefore they need help as to how the system works.<sup>32</sup>

- 8.31 The Committee was told that the submission of claims is a 'confusing and difficult process for veterans to undertake'.<sup>33</sup> The Returned and Services League of Australia (RSL) advocated for a simplified claim form. Rear Admiral (RADM) (Retired) Ken Doolan AO told the Committee of a soldier with a legitimate claim who was so daunted by the paperwork that he had not completed the claim application:

It is confusing ... it was all too difficult and he had just put it in the drawer and was going to leave it there. These [problems] do exist.<sup>34</sup>

- 8.32 The Committee also heard that DVA travel entitlements are cumbersome for the veteran to administer.<sup>35</sup> National Convenor of DFA, Ms Julie Blackburn, told the Committee from their perspective, the claims process did need to be simplified to speed up the transition of claims and processes between Defence and DVA. The feedback from Defence

30 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Submission 3*, p. 5.

31 Name withheld, *Submission 2*, p. 2; Name withheld, *Submission 6*, p. 2.

32 Mr Michael (Baron) von Berg MC, Veterans' Advisory Council of South Australia, *Committee Hansard*, 8 February 2013, p. 24.

33 Name withheld, *Submission 40*, p. 1.

34 Rear Admiral (RADM) (Rtd) Ken Doolan AO, National President Returned and Services League of Australia, *Committee Hansard*, 12 March 2013, p. 5.

35 Name withheld, *Submission 16*, pp. 11–14.



families is that it is still an incredibly complicated system to make a claim, so much so that an advocate is often needed in order to be able to navigate the system.<sup>36</sup>

- 8.33 DVA responded by telling the Committee that the complaints and feedback management system has come a long way as acknowledged by the May 2012 Australian National Audit Office (ANAO) report into the *Management of Complaints and Other Feedback by the Department of Veterans' Affairs*.<sup>37</sup>
- 8.34 In response to the ANAO report, DVA increased staff training and informed supervisors in relation to the use of the complaints and feedback management system. DVA's six-weekly executive management group meetings go through the report of complaints and compliments to get some trend analysis and to understand the issues clients are raising. DVA's quality assurance checks found that most of the mistakes were made during data entry. The ANAO report did recognise that DVA now has better systems, but still needed to do more regarding training and it was because of that DVA implemented the training program.<sup>38</sup>

## Delays in claims

- 8.35 It was submitted that in some instances, claims can become bogged down in a lengthy appeals process and in some cases drag on for more than a year.<sup>39</sup> During this protracted process, the veteran and their partner are often at 'wits end' and may be experiencing financial difficulty, the view being that DVA deliberately drag the process out in the hope of discouraging the applicant from persisting.<sup>40</sup>
- 8.36 The Committee also heard several instances of claims paperwork being lost requiring resubmission, or other irregularities in the paperwork.<sup>41</sup>
- 8.37 DVA responded that for determination of initial liability claims and permanent impairment claims, the target is 120 days on average. DVA advised that for:
- Initial Liability – the average time it took to finalise initial liability claims in 2011-12 was 158 days;

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

37 ANAO, *Management of Complaints and Other Feedback by the Department of Veterans' Affairs*, 3 May 2012.

38 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 9.

39 Name withheld, *Submission 16*, p. 5.

40 Name withheld, *Submission 5*, p. 7.

41 See name withheld, *Submission 14*, p. 2; Name withheld, *Submission 40*, p. 2.

- Permanent Impairment – in 2011-12, the average time it took to finalise permanent impairment claims was 127 days; and
- Incapacity payments – the Department endeavours to finalise claims within 120 days on average. However, there is a mechanism to provide interim payments to clients prior to finalisation of their claims. In 2011-12 the average time it took to finalise claims for incapacity payments was 104 days.

8.38 DVA submitted that the claims process can be protracted as it may involve the claimant having to attend medical appointments, waiting for medical reports, seeking further medical opinion or requesting documentation from the claimant or from the Department of Defence.<sup>42</sup>

### DVA attitude/onus of proof

- 8.39 The Committee heard that there is a perception that DVA will seek to deny or downgrade a claim in the first instance. It was submitted that there is a common view that DVA is seen as ‘a large and opaque department that is geared towards protecting the public purse, hides behind bureaucratic processes, lacks a sense of urgency, and distrusts its client base’.<sup>43</sup>
- 8.40 Dr Khoo told the Committee that he has seen, as a conservative estimate 700 to 1,000 ex-military people with PTSD. He estimated that between one in 10 and one in 15 of the veterans he has treated in the last 10 years had reported a smooth experience in their process to gain DVA recognition and compensation.
- 8.41 Dr Khoo told the Committee that he believes the attitude of DVA seems to have changed from supportive to suspicious. He said that, in his experience, current and former ADF members very rapidly become demoralised and intimidated, and that most of them are additionally traumatised, to a varying extent, by the claim recognition and compensation process:

It is a bureaucratic maze, ... there are three different acts. ... it is very complicated. It is difficult for these people to talk to their own family members, let alone to talk to someone on the end of the phone with no mental health training and no understanding of how difficult the situation has been for them. It is difficult for

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42 Department of Veterans' Affairs, Submission 41, p. 2

43 Name withheld, *Submission 5*, p. 7.

these people to read a magazine, let alone to fill out reams of paperwork. They have lost faith in the system.<sup>44</sup>

## Current claimants

8.42 In the 10 years from 2002 to 2012, DVA accepted 20,577 of 35,490 mental health claims under the VEA and MRCA involving a total of 24,900 veterans.<sup>45</sup> DVA submitted that, for the contemporary cohort of veterans from the East Timor, Solomon Islands, Afghanistan, and Iraq conflicts (see Table below), as at March 2012 there were almost 5,000 veterans from these conflicts known to DVA as having service-related health conditions with around 11,700 accepted conditions. The top three conditions include PTSD, tinnitus, and sensori-neural hearing loss.

Table 8.1 Summary of DVA accepted conditions by recent conflicts (March 2012)

	East Timor	Solomon Islands	Afghanistan	Iraq	Net Total
Veterans with an accepted condition	3,004	309	1,201	1,020	<b>4,973</b>
Total number of accepted conditions	6,835	611	2,789	2,207	<b>11,697</b>
Average conditions/veteran	2.28	1.98	2.32	2.16	<b>2.35</b>

Source Department of Veterans' Affairs, *Submission 18*, p. 9

8.43 The contemporary cohort has served in the context of reform and cultural change in the ADF. This includes the changing role of women in the Defence Force, with increasing numbers of women deployed and the Government formally agreeing to the removal of gender restrictions from ADF combat roles.

8.44 Most of the contemporary veteran cohort continues to be young to middle aged males. The median length of service in the Defence Force is seven years and just over half of serving personnel in the permanent force are aged under 30 years. In 2011, 86% of the ADF permanent forces were male, compared to 87% in 2007.

44 Dr Andrew Khoo, Clinical Director TPH Group Therapy Day Programs, *Committee Hansard*, 25 March 2013, pp. 15, 16.

45 Department of Veterans' Affairs, *Submission 41*, p. 1; see Submission for further details.

- 8.45 Compared to previous cohorts, DVA considers that the contemporary cohort is:
- Less likely to join and participate in formal organisations;
  - More likely to use social network media and less likely to use mainstream media; and
  - More likely to live in non-nuclear family and household arrangements. That said, many will have young families and most will be either married or partnered.<sup>46</sup>

### Claimants' families

- 8.46 DVA submitted that the families of ex-serving personnel are a priority in terms of understanding the contemporary cohort. DVA has been undertaking a research program to assess the impact of service on the health and welfare of the families of deployed personnel, for Vietnam and Timor-Leste veterans. The program is helping DVA and Defence better understand the impact of deployment on families and the kinds of support services that would best help these families.<sup>47</sup>

### Deployed civilians

- 8.47 The Committee notes that in certain instances Defence civilians are deployed on operations and while to date none have been injured, there is potential for the development of psychological issues within this cadre. One submitter believed that the Australian Defence Organisation is not yet mature enough to recognise that civilians are not 'ADF members in a suit', and suggests that a large portion of its civilian workforce may be suffering from conditions like PTSD.<sup>48</sup>

## DVA's cultural transformation

- 8.48 MAJGEN (Retired) Dave Chalmers AO CSC, First Assistant Secretary Client and Commemorations, told the Committee that the secretary of the Department is very concerned to see that DVA does not exhibit the characteristics reported in some submissions. It was said that DVA aims to be client-centric and is looking to empathise with clients and understand the perspective of its clients. He said DVA wants to make sure that they have processes in place which make it as easy as possible for
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46 Department of Veterans' Affairs, *Submission 18*, pp. 9–10.

47 Department of Veterans' Affairs, *Submission 18*, p. 10.

48 Name withheld, *Submission 16*, p. 3.

people to apply for compensation and make claims. The aim is to be as transparent as possible for the client and to minimise barriers so that the process is not harrowing.

- 8.49 He said that DVA is working towards that aim through a cultural transformation process – the On Base Advisory Service is one such cultural change. He told the Committee that DVA’s outreach services are improving, and that they are looking at going online, having introduced the online MyAccount system to make it easier for people to access and understand DVA services. The transition process is being driven by the secretary and it does involve a cultural change:

The department is certainly in the process of transition and cultural change to improve, in every way, the services that it offers to veterans and widows. ... We can always improve our systems.<sup>49</sup>

- 8.50 DVA went on to submit that its Cultural Change program takes a blended learning approach, involving a broad range of delivery mechanisms, including face-to-face workshops, presentations at various forums, specific training for certain job roles, on-the-job training and e-learning, where appropriate. The objectives of the program are to:

- improve staff understanding of our diverse client group, particularly the contemporary clients;
- help build client-focused relationships between DVA staff and clients; and
- enhance DVA’s client service culture and delivery.

- 8.51 The areas covered include:

- understanding military culture and the impact it can have on mental health;
- sessions involving current and former serving members talking about their military experiences and their experiences dealing with DVA;
- sessions involving senior DVA management, including the Secretary, covering the strategic challenges facing DVA;
- managing challenging behaviours from clients;
- suicide awareness;
- strategies for dealing with complex cases; and
- strategies for taking a more client-centric or whole-of-client approach to service delivery.<sup>50</sup>

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49 MAJGEN (Rtd) Dave Chalmers AO CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 19 March 2013, p. 2.

50 Department of Veterans’ Affairs, *Submission 41*, p. 4.

## Ongoing health care and support

- 8.52 DVA submitted that as at March 2012, they provide support to almost 335,000 clients, whether by a pension, allowance, or treatment card. As discussed, DVA claimed to be transforming the way it is dealing with clients across a range of functions, in order to provide more flexibility in support and care.
- 8.53 DVA submitted that it is continuing to expand its range of communication channels, including options for clients to deal with the Department online. These new channels are complementary and will not replace the traditional forms of communication, as veterans and their families will still be able to contact the Department via telephone, face-to-face, fax, email or mail.<sup>51</sup>
- 8.54 Additionally, DVA stressed to the Committee that strategies have been put in place for dealing with vulnerable or at risk clients, including:
- The Client Liaison Unit which assists in the interactions between DVA and vulnerable clients, including those with complex needs. Clients may be referred from within the Department if there is a breakdown in relationship between client and an area of the Department; and
  - Case coordinators for clients with complex needs who have caused, or may be in danger of causing, harm to themselves or to others. Case coordinators assist at-risk clients with complex needs to navigate DVA services and benefits in order to minimise their risk of self-harm and maximise their quality of life. Coordinators also provide a primary point of contact for clients and assist them and their families with other psychosocial needs external to the Department to help them enhance their quality of life. Participation in case coordination is voluntary and therefore a client can choose to accept or decline the service.<sup>52</sup>

## Case management

- 8.55 Associate Professor Robert Atkinson AM RFD, Clinical Associate Professor in Orthopaedic Surgery with the University of Adelaide, submitted that a process to 'spot check' a patient's journey and procedures to acknowledge success and identify if and where improvements could be gained was warranted.<sup>53</sup>

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51 Department of Veterans' Affairs, *Submission 18*, p. 18.

52 Department of Veterans' Affairs, *Submission 18*, p. 18.

53 Associate Professor Robert Atkinson AM RFD, *Submission 1*, p. 1.

- 8.56 Other evidence suggested that the DVA case management process requires 'thorough investigation and update'<sup>54</sup> or at least that the service provided by case managers lacks a level of appropriate care<sup>55</sup> or effort<sup>56</sup>. The Vietnam Veterans' Federation has received complaints about restrictions on retraining outsourced case managers, and the quality of some who are sometimes 'young and inexperienced'.<sup>57</sup>
- 8.57 The Australasian Services Care Network (ASCN) highlighted in their submission that support of the 'patient's journey' with a quality case management system is paramount for effectiveness. This not only ensures the correct therapeutic regime is delivered, but has the potential to deliver a better quality of life and a more effective cost management process.<sup>58</sup>

### Ex-serviceman involvement

- 8.58 The Returned and Services League of Australia WA Branch (RSL WA) submitted that while their assessment is that DVA has competent Case Managers, at times members feels more comfortable talking about their problems with an ex-service member.<sup>59</sup> This was a recurring theme with veterans noting that having another veteran as a Case Manager (who may even be suffering from the effects of PTSD or other mental health issues themselves) have a genuine desire to help other veterans and give something back to the community.<sup>60</sup> 'Soldier F' told the Committee:
- [My experience with DVA has been] excellent. I have got a very good counsellor .... He has looked after me. He has really put the right claims in for me. He has helped me out. ... He actually served with my father in Vietnam so he has a lot of experience and has helped out immensely.<sup>61</sup>
- 8.59 It was submitted that there is variability in the level of service and range of difficulties in the claims process in different states and that a standardised approach to recruitment, training and ongoing evaluation of Case Managers is needed to assist in delivering a consistent level of

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54 Name withheld, *Submission 2*, p. 2.

55 Carry On (Victoria), *Submission 10*, p. 2.

56 Name withheld, *Submission 16*, p. 3.

57 Vietnam Veterans' Federation, *Submission 25*, p. 1.

58 Australasian Services Care Network, *Submission 39*, p. 2.

59 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1. Name withheld, *Submission 40*, p. 1.

60 Name withheld, *Submission 5*, p. 7.

61 Soldier F, *Committee Hansard*, 25 October 2012, p. 11.

service through these outsourced arrangements, to include counselling skills.<sup>62</sup>

- 8.60 MAJGEN Cosson responded that a range of initiatives have been put in place to try to respond to the contemporary veteran issue. Client and Commemorations Division has been established to make sure that DVA understand the client and emerging needs. She told the Committee that a powerful, interactive 'Understanding Military Culture' workshop is conducted which engages ex-serving personnel to lead discussions on what it is like to have military service and what it means to them and their family. More recently, DVA has been emphasising connecting with the clients:

Look at them as a person, not as a claim and not as a condition; treat the client as a whole person and with their family; and actually make that connection, pick up a telephone and talk to the client about what their needs are or what the contemporary veteran needs are.<sup>63</sup>

- 8.61 From a treatment point of view, Professor Sandy McFarlane AO told the Committee that he believes a clinician who understands the culture, the structure of the organisation and how to address the issues of the ongoing functioning of those individuals within the organisation is needed. Using people outside the system who do not have an intimate knowledge from an occupational perspective is, he says, a critical issue.<sup>64</sup> Dr Glen Edwards told the Committee 'It is veterans who help veterans'.<sup>65</sup>
- 8.62 Professor David Forbes, the Director of the Australian Centre for Post-traumatic Mental Health (ACPMH) did not doubt that an ex-serviceman would bring an intimate knowledge of Defence. He said, however, that it was not a key ingredient and does not compare to the support and intervention that a health professional would provide.<sup>66</sup>
- 8.63 MAJGEN Cosson advised that since 2010, DVA started putting more emphasis on dependants, particularly young widows. DVA has interviewed them and talked to them about what their experience has been with DVA. She told the Committee that the wives were very frank and they told DVA about some of the areas of concern – that DVA gave

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62 Name withheld, *Submission 5*, p. 8.

63 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, pp. 10-11.

64 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 1.

65 Dr Glen Edwards, *Committee Hansard*, 8 February 2013, p. 11.

66 Professor David Forbes, Director Australian Centre for Post-traumatic Mental Health, *Committee Hansard*, 7 December 2012, p. 14.



them too much information, did not personalise the process, and that DVA needed to do a lot more work in engaging with them.

- 8.64 She went on to explain that this led to DVA establishing new service coordinators to have one-on-one contact with the dependants, and, importantly, establishing a very close connection with Defence and DCO early in the process. She said that DVA have done a similar round of work with soldiers who have returned seriously wounded and injured, and their families:

It is a journey through their life that we will be part of – establishing that journey map with them was really important work for us, really helping our staff understand that contemporary veterans do have different needs and different expectations, but it all comes down to the communication.<sup>67</sup>

## Long term injuries and illnesses

- 8.65 DVA acknowledged to the Committee that they are aware that there are also longer term injuries and illnesses that may emerge over time, either due to the delayed onset of symptoms or due to advances in knowledge and diagnosis such as:
- For mental health, some conditions may take some time for symptoms to present. For example, PTSD, anxiety, or depression may have a delayed onset months or years after a causal event or events;
  - Traumatic brain injury has come under increasing attention by military medicine in terms of concussive injuries. As a result of blast injuries and the use of improvised explosive devices in recent Middle East Areas of Operations (MEAO), mild traumatic brain injury (MTBI) is emerging as a particular focus. While there is an international body of evidence on the prevalence and impact of this injury, there is also ongoing discussion on the methods used to measure and diagnose it, particularly as the symptoms may mask PTSD or other mental health disorders; and
  - Musculoskeletal conditions resulting from traumas to the body in either a minute or major way may also emerge over time. For some, this can also include the need for ongoing pain management and managing potential risks of mental health problems associated with ongoing pain.

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<sup>67</sup> MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 11.

- 8.66 DVA also acknowledged that each injury is unique in terms of effects on the individual and their family, and the care and support they subsequently need. While members remain in the military, the ADF has primary responsibility although there are some areas that DVA can provide support to them. DVA takes full responsibility for care and support for those wounded or injured personnel who leave the ADF. The types of care and support include:
- Medical treatment and care, such as occupational therapy, physiotherapy or allied health treatment;
  - Mental health treatment;
  - Rehabilitation services;
  - Home modifications, including for access points to the home and for use of kitchens and bathrooms;
  - Motor vehicles, for instance hand control options and wheelchair options;
  - Home equipment, such as kitchen packs with appropriate knives, non-slip mats, one-handed tools/implements, specialised beds, custom wheelchairs and home exercise/gym equipment;
  - Domestic, gardening and personal care services; and
  - Financial support, short or longer term.<sup>68</sup>
- 8.67 RSL South Australia highlighted the importance of support for the carers and families of seriously wounded soldiers.<sup>69</sup>

## Rehabilitation

- 8.68 DVA submitted that the passage of the MRCA increased the focus and primacy placed on rehabilitation as part of the overall repatriation system for current and former serving men and women. For wounded or injured ex-serving personnel, rehabilitation is an essential part of their overall care and support.
- 8.69 Greater success in rehabilitation and retention within the ADF means that those who are discharged are generally in higher needs categories than they would be in any other civilian rehabilitation or compensation scheme. The options of return to work in their original and usually preferred workplace or a similar position elsewhere in the ADF may have been exhausted. The ADF member has to pursue new opportunities and challenges while sometimes dealing with increased incapacity.

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68 Department of Veterans' Affairs, *Submission 18*, pp. 8-9.

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

- 8.70 DVA's response is to use a tailored approach to meet the needs of the individual after discharge, which addresses social, psychological, vocational and educational factors based upon the following principles:
- Care and respect for the client is paramount;
  - Early intervention processes and practices must operate;
  - Whole of person rehabilitation needs must be addressed;
  - The client, and their significant other, must be actively involved in the development of an appropriate rehabilitation plan/program with realistic goals;
  - All key stakeholders must be actively involved in an effectively coordinated plan/program of activities; and
  - Rehabilitation plans must be focussed on outcomes.
- 8.71 Rehabilitation programs can include medical, dental, psychiatric, in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars. Attachment C of Submission from the Department of Veterans' Affairs sets out the 'whole of person' approach used in rehabilitation, including medical, psychosocial, and vocational aspects.<sup>70</sup>
- 8.72 The Committee received evidence that current DVA vocational rehabilitation does not support all younger veterans in obtaining meaningful employment. The Committee was informed that some veterans who cannot undertake physical occupations due to the extent of their wounds and injuries are missing support such as higher level education due to legislative limitations.<sup>71</sup>

## Chronic disease management

- 8.73 DVA is also working on new methods for chronic disease management and care coordination. For instance, DVA submitted that the Coordinated Veterans' Care Program is a positive step to improve the wellbeing and quality of care for chronically ill Gold Card holders, including through team based care and careful targeting of chronically ill patients. The program pays general practitioners and nursing providers to coordinate care for Gold Card holders who are at risk of hospitalisation. Through

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<sup>70</sup> Department of Veterans' Affairs, *Submission 18*, pp. 18-19.

<sup>71</sup> Name withheld, *Submission 40*, pp. 4-5.

improved community based care, the program is intended to improve the health of participants by:

- Providing ongoing planned and coordinated care from the general practitioner and a nurse,
- Educating and empowering participants to self-manage their conditions, and
- Encouraging the most socially isolated to participate in community activities.<sup>72</sup>

8.74 RSL South Australia submitted that long-term care of seriously wounded personnel who require 24 hour support is not being met with the placement of these individuals into aged care facilities or disabled group homes.<sup>73</sup>

## Mental health

8.75 MAJGEN Cosson gave evidence that there is a comprehensive range of programs, services and benefits provided by DVA and available for former serving ADF members and their families. This includes the VVCS, PTSD programs, online mental health information and support, and medical and hospital services.<sup>74</sup>

8.76 Ms Judy Daniel, First Assistant Secretary, Health and Community Services explained that provisions within DVA legislation allow for non-liability health cover for PTSD, anxiety and depressive disorders. That arrangement means that health cover is available on diagnosis, without the need to go through the compensation process and link the condition to service. The compensation process is different and separate. There is, however, provision to provide access to mental health treatment.<sup>75</sup>

8.77 To reach members of the veteran and ex-service community on mental health matters, including those who are reluctant or unable to seek help, the Department uses education and awareness activities to promote good mental health and help-seeking behaviours. *At Ease* is a self-help website<sup>76</sup> offering mental health and wellbeing information and resources for veterans and serving personnel, their families, friends and carers as well as health providers.

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72 Department of Veterans' Affairs, *Submission 18*, p. 22.

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

74 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

75 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 19 March 2013, p. 4.

76 See <[www.at-ease.dva.gov.au](http://www.at-ease.dva.gov.au)>.

- 8.78 A focus for DVA is developing new channels of communication to strengthen their engagement with contemporary veterans and their families, including new technologies such as mobile phone applications. A range of mobile phone applications are either being developed or in preliminary planning stages, including:
- An Australian version of the United States Veterans' Affairs PTSD Coach with enhanced functionality and engagement with allied mental health providers (through *At Ease*) and VVCS providers to incorporate the application into treatment regimes;
  - *The Right Mix* alcohol management to assist contemporary veterans manage their drinking behaviours;
  - Suicide awareness tools and information to support those at risk and their families, under the *Operation Life* framework; and
  - A mobile version of the *Wellbeing Toolbox* providing interactive self-care tools to support personnel who are leaving the ADF.
- 8.79 These initiatives are in a context of a wide range of mental health treatment services that are purchased and provided by the Department, including GP services, psychiatric services, psychologist services, pharmaceuticals, and hospital services. In addition, DVA also supports direct services through the VVCS, which provides free and confidential counselling either face-to-face at one of the 15 VVCS Centres nationally, or through the 24-hour hotline.<sup>77</sup>
- 8.80 The Committee agrees that VVCS is a very good organisation offering a wide range of programs and counselling services to veterans and their families.<sup>78</sup>
- 8.81 Non-liability healthcare is available to eligible veterans with PTSD, anxiety and depressive disorders to treat these conditions. Non-liability health care provides access to treatment for eligible clients (this includes those who have sustained wounds or injuries from operational service). Those with non-liability cover for these conditions have access to a range of clinically needed mental health services, irrespective of whether or not the PTSD, anxiety and depressive disorders is service-related.
- 8.82 The work of Defence in identifying mental health prevalence through the 2010 ADF Mental Health Prevalence and Wellbeing Survey will be an important consideration for DVA's approach to mental health in the future.<sup>79</sup>

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77 Department of Veterans' Affairs, *Submission 18*, pp. 19–20.

78 Name withheld, *Submission 16*, pp. 8–9.

79 Department of Veterans' Affairs, *Submission 18*, p. 20.

- 8.83 RSL WA submitted that there is evidence that there is an increase in mental health problems, resulting in more ADF personnel discharging with mental and other undiagnosed conditions.<sup>80</sup>
- 8.84 Associate Professor Susan Neuhaus CSC submitted that the previously noted fragmentation of Defence and DVA health care systems meant that, while ADF personnel wounded and injured during service in operational areas are acknowledged, the burden of 'unseen wounds', in particular the results of mental health injury sustained on recent operations, are not likely to emerge for many years. Additionally, the physical impacts of service may also take a considerable time to be recognised (e.g. back injuries, effects on future fertility or cancer risk).
- 8.85 There are a number of vulnerabilities, particularly for those without established claims, and for those who may not be aware of the linkages of their condition to their service. This is of particular relevance post transition from the ADF. As previously noted, this complexity, and the lack of a unique veteran identifier within Federal, State and Territory health organisations, creates challenges as it relies on the individual and/or their health professional to make a linkage of their medical condition to a particular aspect of their service.<sup>81</sup>
- 8.86 The civilian health sector is also often unaware of a younger veteran's service history and little systematic assessment occurs of the associated risk factors which may have contributed to their current health status.<sup>82</sup>
- 8.87 DFA also noted that there needs to be greater public awareness of the unique needs of ADF members within the broader health system to ensure that health carers know how to identify and manage ADF or former ADF personnel that may be admitted or in their care.<sup>83</sup> This was echoed by Carry On (Victoria) who further recommended a deliberate ongoing monitoring program.<sup>84</sup>
- 8.88 DVA do not currently have a regular and formalised system for tracking those who have left the defence forces. As a means to address this gap, particularly for the contemporary veteran, DVA is ensuring that they have a good on-line presence using the internet. For example, the Touch Base program is a pilot program providing support for separating Defence Force members and short YouTube clips with a mental health focus. DVA

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80 Returned and Services League of Australia WA Branch, *Submission 4*, p. 1.

81 Associate Professor Susan Neuhaus CSC, *Submission 31*, pp. 2-3.

82 Veterans' Health Advisory Council, *Submission 33*, p. 3.

83 Defence Families of Australia, *Submission 8*, p. 3.

84 Carry On (Victoria), *Submission 10*, pp. 1-2.

submitted that this range of strategies also maintains awareness within the broader health service community.

- 8.89 DVA accepted that ensuring that the general health provider community has a good awareness of veterans' health issues and the impact military service can have on health is a challenge – in particular, mental health.<sup>85</sup>
- 8.90 The Australasian Services Care Network (ASCN) submitted that it is also important to involve the aged care industry to ensure adequate provisioning for later stages of life. ASCN submitted that a cooperative approach would be cost effective, particularly when increasing mental health issues have the potential to change age care demands. They also highlight that younger individuals requiring accommodation and services may require a change to the traditional description of 'aged care' to 'aged and chronic care'. They are concerned about the longer term effects of MTBI, as an example, and the potential relationship to early on-set Alzheimer's disease and dementia.<sup>86</sup>

## Compensation

- 8.91 The Committee received evidence expressing a range of views on the provision of compensation for wounds and injuries. Some individuals reported a prompt and fair compensation process,<sup>87</sup> while others have had to wait substantial periods or are yet to receive compensation,<sup>88</sup> or that despite DVA having accepted liability, compensation for a permanent injury has not been provided and that DVA will use any excuse not to provide compensation.<sup>89</sup> The Committee also heard that incapacity payments should properly reflect the real financial losses suffered by veterans.<sup>90</sup>
- 8.92 The Vietnam Veterans' Association of Australia (VVAA) submitted that 'a constant complaint' is in relation to the MRCA where a disability or injury can be accepted as service related, however the assessment of other entitlements (that is; treatment, rehabilitation and compensation) are subject to a further level of assessment. VVAA submitted that MRCA procedures can be lengthy and stressful to ex-service personnel when

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85 Ms Judy Daniel, First Assistant Secretary Health and Community Services, *Committee Hansard*, 9 October 2012, p. 12.

86 Australasian Services Care Network, *Submission 39*, p. 2.

87 Name withheld, *Submission 2*, p. 1.

88 Name withheld, *Submission 2*, p.2.

89 Name withheld, *Submission 9*, p. 1.

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

compared with the VEA because under the VEA, assessment is part of the acceptance process and handled in a much timelier manner.<sup>91</sup>

- 8.93 It was submitted to the Committee that permanent impairment assessments based on the Guide to the Assessment of Rates of Veterans' Pensions (GARP) and related legislation is geared to cater for senior veterans, and therefore fails to appropriately incorporate the different needs of younger veterans.<sup>92</sup>
- 8.94 Regardless, Austin Health's Psychological Trauma Recovery Service (PTRS) submitted that their strong recommendation is that the provision of treatment and rehabilitation remains separated from consideration of compensation.<sup>93</sup>
- 8.95 Dr Edwards' experience is that most veterans seek treatment for their health issues, not for compensation, despite often being economically disadvantaged due to their service. He submitted that there is an obligation to provide what is necessary to ensure the best quality of life for each ADF individual and family member.<sup>94</sup>

## Research

- 8.96 Professor Neuhaus submitted that the inadequacy of appropriate services following the Vietnam conflict is well recognised and that it is in the area of PTSD that the greatest legacy from ADF operations in recent years is likely to come. She submitted that delays in recognising, understanding, or responding to the health issues of our current generation of ADF service personnel will impact not only individual veterans, but their families and the broader community, through the social and economic burden and health care cost to broader support systems.
- 8.97 She highlighted that it was critical, for current and future veterans, that active health advocacy and research is undertaken but that care of wounded, injured and ill service personnel and veterans is currently underpinned by a fragmented research agenda. She championed a national strategic health research program addressing the needs of ADF personnel wounded or injured on operations, and the subsequent veteran cohort.<sup>95</sup>

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91 Vietnam Veterans' Association of Australia, *Submission 27*, p. 5.

92 Name withheld, *Submission 40*, pp. 1, 4-5.

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

94 Dr Glen Edwards, *Submission 34*, p. 3.

95 Associate Professor Susan Neuhaus CSC, *Submission 31*, pp. 3-4.



## DVA's readiness for the future

8.98 DVA submitted that it believes its work to transform its service delivery models will position the Department well to manage the changing veteran environment. In particular, the Department cited:

- The investment in understanding the characteristics of the contemporary cohort of veterans, including those who have been wounded or injured, means DVA is well placed to continue to meet client needs and expectations;
- The more flexible and simple process of when and how claims may be made, means greater responsiveness for recognising service-related injuries. The more visible and pro-active DVA presence in the ADF means personnel are more aware of the help and support they can access when they need it;
- The close work with the ADF will help make the process of discharge from the military into civilian life as smooth as possible, including for those personnel who have sustained wounds or injuries from their service; and
- The development of the new service models and other reforms places the client at the centre of service delivery, in order to allow DVA be able to provide a more pro-active and tailored service to meet client need.<sup>96</sup>

8.99 As to the likely future needs, DVA again acknowledged that some conditions may take some time before symptoms present or become known to the individual and his or her family, or before symptoms reach a level that the individual wishes to seek help (or is encouraged to do so by a spouse or family member). For instance, with the delayed onset of PTSD, symptoms may take years before they become apparent. Critically, DVA submitted that its system recognises delayed onset of symptoms and is sufficiently flexible to accommodate advances in knowledge and scientific evidence.

8.100 The knowledge and evidence about some wounds and injuries may also take some time to emerge, and there may be delays in diagnosis. As noted earlier, MTBI is an emerging issue as a result of blast injuries and the use of improvised explosive devices (IED) in the MEAO.

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<sup>96</sup> Department of Veterans' Affairs, *Submission 18*, p. 23.

- 8.101 DVA submitted that through its research program, and in collaboration with Defence, they will continue to monitor prospective health needs. Particular forthcoming studies include:
- The MEAO Prospective Health Study that will provide the most up to date information on current physical and psychological effects of this deployment, and
  - Further analysis arising from the *2010 ADF Mental Health Prevalence and Wellbeing Study*.
- 8.102 The Department will also continue to consult with the ex-service community about emerging needs and how these needs may be effectively addressed.<sup>97</sup>

## Committee comment

- 8.103 The Committee supports DVA's stated service delivery model which includes a single point of contact for case management. However noting the evidence raised during the Inquiry, the Committee believes that despite DVA's efforts to date, the veteran community still feels a great deal of dissatisfaction with DVA's services.
- 8.104 The Committee applauds DVA's intention to have a single electronic form claim process, responsive to all applicable legislation, and strongly encourages DVA to hasten its development.
- 8.105 The Committee notes that DVA provides free treatment for PTSD, depression and anxiety to eligible veterans with operational service, irrespective of whether it is service related.<sup>98</sup>
- 8.106 The Committee acknowledges that DVA has increased the training emphasis on cultural understanding and empathy by their Case Managers in dealing with customers but remains concerned about the ongoing issues reported to the Committee. The Committee agrees that there is an argument that ex-service personnel may bring a heightened understanding to the role of Case Manager, and should be preferentially employed in this capacity. The Committee notes, however, that these individuals themselves may be suffering ill health due to their service, and this risk would need to be carefully managed.

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97 Department of Veterans' Affairs, *Submission 18*, p. 23.

98 MAJGEN (Rtd) Elizabeth Cosson AM CSC, First Assistant Secretary Client and Commemorations, *Committee Hansard*, 9 October 2012, p. 8.

- 8.107 The Committee agrees that research into long term mental health and other related issues (for example links to Alzheimer's or dementia) is of paramount importance.

### **Recommendation 23**

The Committee recommends that the Department of Veterans' Affairs:

- Review the Statements of Principles in conjunction with the Repatriation Medical Authority with a view to being less prescriptive and allowing greater flexibility to allow entitlements and compensation related to service to be accepted;
- Periodically publish reports measuring success in adhering to their client service model;
- Periodically publish claim processing times; and
- Periodically publish claim success rates.

### **Recommendation 24**

The Committee recommends that the Department of Veterans' Affairs conduct a study, and publish the results, reflecting the issues raised in evidence during the Inquiry, concerning:

- Developing a standardised approach to recruitment, including the preferential recruitment of ex-service members as Case Managers; and
- Training and ongoing evaluation of Case Managers.



## Veterans' Support Structures

- 9.1 The final Chapter acknowledges the many government, non-government, non-profit and ex-service organisations in Australia which support veterans, wounded and injured or otherwise, and specifically acknowledges their contribution to the Inquiry. It finishes by considering broad-scale coordination requirements for veteran services.
- 9.2 The Committee received evidence from a multitude of organisations, both public and private, which support our wounded and injured Australian Defence Force (ADF) members. The Vietnam Veterans' Association of Australia (VVAA) noted the importance of support organisations, submitting that while the Department of Veterans' Affairs (DVA) procedures for dealing with ongoing health care and support are adequate, a considerable degree of support and assistance is being sought from the ex-service and broader community. VVAA submitted that support organisations are well placed to provide such support, and can provide a buffer between ex-service personnel and the government bureaucracy that they are cautious of dealing with directly.<sup>1</sup>

### Support organisations

- 9.3 The Committee received submissions from a number of support organisations.

### Australasian Services Care Network

- 9.4 Australasian Services Care Network (ASCN) is a 'community of practice' of Australasian providers of care and accommodation services, primarily to the Service and ex-Service community and their families. The group

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1 Vietnam Veterans' Association of Australia, *Submission 27*, p. 5.

was created following the inaugural Defence Community Forum in 2011, and provides a network for providers to share insights, create a unified 'voice', work collectively and collaborate, form public policy positions, work with other international ex-Service care provider bodies, and enhance outcomes for the Network and their beneficiaries. Membership is open to providers of care and accommodation services to the Service and ex-Service community of Australia and New Zealand.<sup>2</sup>

## Australian Centre for Post-traumatic Mental Health

9.5 The Australian Centre for Post-traumatic Mental Health (ACPMH) is a not-for-profit incorporated association, affiliated with the University of Melbourne's Department of Psychiatry, whose vision is improved wellbeing and quality of life for individuals and communities who experience trauma, with a particular focus on current and former members of the Defence community. It works to achieve this vision through an integrated model of provision of policy and service development advice, research, and education and training activities.<sup>3</sup>

## Carry On (Victoria)

9.6 Carry On (Victoria) is an ex-service welfare organisation operating solely in Victoria and are a major supplier of welfare assistance to the Victorian ex-service community which predominantly provides low cost rental accommodation, mainly in rural cities; education assistance to children of veterans; and general welfare in the form of advice, guidance and financial assistance.<sup>4</sup>

## Centori Pty Ltd

9.7 Centori is a privately owned and independent Australian adventure company creating opportunities to experience worldwide leisure and peak adventure travel for wounded soldiers amongst other groups. It offers activities ranging from high altitude climbing, bespoke trekking, endurance kayaking, walking safaris through big game areas of Africa, unique corporate Road Trips, to tailored travel covering Australian military history. The company made its name on the Kokoda Track, but now offers programs on every continent.<sup>5</sup>

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2 Australasian Services Care Network, *Submission 39*, p. 1.

3 Australian Centre for Post-traumatic Mental Health, *Submission 23*, p. 1.

4 Carry On (Victoria), *Submission 10*, p. 1.

5 Centori, viewed 21 March 2013, <[www.centori.com.au](http://www.centori.com.au)>.

## Centre for Military and Veterans' Health

9.8 The Centre for Military and Veterans' Health (CMVH) is an internationally-unique academic, community and military partnership funded by the Departments of Defence (Defence) and Veterans' Affairs (DVA). CMVH have a team of researchers, health practitioners and serving ADF personnel who work together to better understand and address health issues affecting military personnel, veterans, and their families through: research; military-specific professional development opportunities for health professionals; and Think Tank Forums to provide opportunities for high-level strategic input to the military health debate.<sup>6</sup>

## Defence Families of Australia

9.9 Defence Families of Australia (DFA) is a ministerially appointed group that specifically represents the views of Defence families. Its aim is to inform Government and Defence on the needs of the family. Its goal is to ensure quality of life for all Defence families by providing a recognised forum for their views, and by reporting, making recommendations and influencing policy that directly affects families, and in turn, enhancing the capability of the Defence Force.<sup>7</sup>

## Go2 Human Performance

9.10 Go2 Human Performance assists people to alter limiting beliefs, increase confidence and develop mental fitness. Over 20 years, Go2 Human Performance's work and self-management programs claim to have assisted thousands of people including wounded and injured veterans change their lives and deal with most illnesses. Go2 Human Performance staff have a combination of professional backgrounds in the behavioural sciences and dynamic contemporary techniques.<sup>8</sup>

## Legacy Australia

9.11 Legacy Australia (Legacy) is an organisation that began in the years after World War I and has as its role the support to the families of incapacitated and deceased veterans. Legacy cares for dependants of those who served their country; namely veterans who died (or were incapacitated) on

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6 Centre for Military and Veterans' Health, viewed 21 May 2013, <[www.cmvh.org.au](http://www.cmvh.org.au)>.

7 Defence Families of Australia, viewed 16 May 2013, <[www.dfa.org.au](http://www.dfa.org.au)>.

8 Go2 Human Performance, viewed 19 March 2013, <[www.go2humanperformance.com.au](http://www.go2humanperformance.com.au)>.

operational service or subsequently died as a result of their service.<sup>9</sup> Mr Tony Ralph, President of Brisbane Legacy highlighted that:

Children [of fallen soldiers] will always be Legacy wards. We will always provide services to the children provided the mother and the children want them.<sup>10</sup>

## Psychological Trauma Recovery Service

9.12 The Mental Health Clinical Service Unit (MHCSU) is one of several Clinical Service Units within Austin Health and comprises a range of mental health services including specialist and state-wide services including the Psychological Trauma Recovery Service (PTRS) which is Austin Health's specialist Mental Health Service for the treatment of Trauma-related Mental Health Disorders (TRMHDs).<sup>11</sup>

## Returned and Services League of Australia

9.13 The aims and objectives of the Returned and Services League (RSL) are to perpetuate the close ties of friendship created by mutual service in the ADF or allied forces, to maintain a proper standard of dignity and honour among all past and present serving members of the Defence Force and to set an example of public spirit and noble hearted endeavour. They do this in order to; preserve the memory and records of those who suffered and died for Australia; provide for the sick and wounded and needy among those who have served and their dependents including pensions, medical attention, homes and suitable employment; inculcate loyalty to the Nation, to guard the good name and preserve the interests and standing of members of the Defence Force; and to promote RSL policy on national questions.<sup>12</sup>

## Soldier On

9.14 Soldier On is a charity supporting those who have been wounded on contemporary operations. The charity allows for the Australian community to connect to those that have been wounded and to support their re-integration back into Australian society through providing access to inspirational activities, supporting rehabilitation and providing opportunities that empower individuals.<sup>13</sup>

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9 Legacy Australia Council, *Submission 12*, pp. 1, 6.

10 Mr Tony Ralph, President, Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 20.

11 Austin Health, *Submission 24*, p. 2.

12 Returned and Services League of Australia, viewed 21 May 2013, <[www.rsl.org.au](http://www.rsl.org.au)>.

13 Soldier On, *Submission 15*, pp. 1-2



## Toowong Private Hospital

9.15 Toowong Private Hospital (TPH) is recognised as Queensland's leading private mental health care facility and is seen as a specialist centre in veterans' mental health. The TPH Group Therapy Day Programs area has run outpatient cognitive behaviour therapy-based group therapy programs for currently serving ADF personnel and ex serving members with Post-Traumatic Stress Disorder (PTSD) and Alcohol and Drug (A&D) addiction for the last 12 years and their programs are accredited by the ACPMH.<sup>14</sup>

## Trauma Release Australia

9.16 Trauma Release Australia use trauma release exercises (TRE) in an approach that deliberately uses the body's innate process of involuntary shaking and tremors in a safe and controlled way to physically release the effects of chronic stress and unresolved trauma including PTSD.<sup>15</sup>

## Veterans' Health Advisory Council

9.17 The Veterans' Health Advisory Council (VHAC) advises the South Australian Minister for Health and Ageing, Mental Health and Substance Abuse, Defence Industries and Veterans' Affairs on the health issues of veterans, war widows and their families and advocates on their behalf.<sup>16</sup>

## Vietnam Veterans' Association of Australia

9.18 The aim of the Vietnam Veterans' Association of Australia is to assist all veterans, dependants and their descendants in all matters relating to their health, welfare and wellbeing.<sup>17</sup>

## Vietnam Veterans' Federation of Australia

9.19 The Vietnam Veterans' Federation of Australia (VVFA) and its affiliated partners, the Vietnam Veterans Peacekeepers and Peacemakers Association of Australia (VPPAA), are dedicated to the welfare of all service and ex-service personnel and their families. VVFA is made up of volunteers who chose to help veterans in need.<sup>18</sup>

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14 Dr Andrew Khoo, *Submission 3*, p. 1.

15 Trauma Release Australia, viewed 21 May 2013, <[www.traumareleaseexercises.com.au](http://www.traumareleaseexercises.com.au)>.

16 Veterans' Health Advisory Council, viewed 21 May 2013, <[www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)>.

17 Vietnam Veterans' Association of Australia, viewed 21 May 2013, <[www.vvaa.org.au](http://www.vvaa.org.au)>.

18 Vietnam Veterans' Federation of Australia, viewed 21 May 2013, <[www.vvfagraville.org](http://www.vvfagraville.org)>.

## Young Diggers

- 9.20 Young Diggers is a not-for-profit organisation dedicated to providing on-line care and welfare to all serving and ex-serving military personnel and their families. Young Diggers operate in association with the Goodna RSL sub-branch and services club, but remain independent in operation.
- 9.21 When contacted, Young Diggers communicates with the person and when they are ready, refers them to the appropriate people like the Veterans and Veterans' Families Counselling Service (VVCS), a pensions officer in their area, or other appropriate support services. Young Diggers provide a confidential service, a non-military organisation who understands, a non-government organisation that can be trusted, easy to talk to ex-military volunteers who have 'been there', and a voice, in a safe environment, where veterans can share their feelings and experiences with others.<sup>19</sup>

## Gaps and overlap

- 9.22 Mr Tony Ralph, the President of Brisbane Legacy, told the Committee that the primary agencies, Defence and DVA, focus on the veteran and it is left to organisations such as Legacy to support families. He suggested that if Defence and DVA engaged with organisations such as Legacy at a very early stage, it would be a more holistic experience for the member and their family and that the support of Legacy and other organisations could become more compatible with that of the larger organisations.<sup>20</sup>
- 9.23 When he was asked about the formation of Soldier On and if it was the result of some perceived deficiency in the way that Defence and DVA were providing support to veterans, Professor Peter Leahy AC responded:
- It is very much an extra. We do not think there is a deficiency. When you look at the sum total that is available – the RSL are doing great work, Legacy is doing great work, and there are some other charities starting out there.<sup>21</sup>
- 9.24 Professor Leahy went on to say that Soldier On is conscious that there are different structures and organisations providing support to wounded and injured veterans. Soldier On is therefore actively consulting with larger support organisations to ensure that they are not 'treading in someone

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19 Young Diggers, viewed 20 March 2013, <[www.youngdiggers.com.au](http://www.youngdiggers.com.au)>.

20 Mr Tony Ralph, President Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 16.

21 Professor Peter Leahy AC, Chairman Soldier On, *Committee Hansard*, 27 November 2012, p. 2.

else's lane' or 'duplicating work and effort'. He also noted that support arrangements varied from state to state.<sup>22</sup>

- 9.25 When asked about coordination of services, Mr Brian Freeman, the Director of Centori Pty Ltd, told the Committee that sometimes there might be some niche areas in the marketplace which 'put the horse before the cart' rather than delivering a solution. Nonetheless he did not think that collaboration is as important now as it might have been in the past, particularly since RSL Queensland had committed to providing funding and coordination. He submitted that organisations supporting wounded and injured provide their services in different areas. He did say, however, if they were to all come together, they would be a more powerful entity than they are individually.<sup>23</sup>
- 9.26 The President of Young Diggers Australia, Mr John Jarrett, gave evidence that there are a lot of organisations assisting veterans with, for example, welfare and DVA claims:
- There are lots of ex-service organisations that are able to give the same advice and do the same DVA claims, as long as they are up with all the legislation.<sup>24</sup>
- 9.27 Mr Tony McHugh, the Manager and Principal Psychologist with PTRS, gave evidence that, even in the Vietnam era, due to the large number of well-motivated and well-intentioned returning Vietnam veterans, there were multiple organisations attempting to represent them. He highlighted that now there are even more organisations for recently returned veterans but advised the Committee that the uptake of membership is not great.<sup>25</sup>
- 9.28 The Committee notes that this aligns with DVA's assessment of the current cohort of veterans; that they tend not to join groups.
- 9.29 Carry On (Victoria) gave a somewhat grimmer observation. Mrs Cheryl Hersey, Carry On's Welfare Officer, told the Committee candidly that there is a gap between an individual transitioning out of the Services and eventually seeking assistance.<sup>26</sup>

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22 Professor Peter Leahy AC, Chairman Soldier On, *Committee Hansard*, 27 November 2012, pp. 5, 7.

23 Mr Brian Freeman, Director, Centori Pty Ltd, *Committee Hansard*, 25 March 2013, p. 9.

24 Mr Mervyn (John) Jarrett, President Young Diggers, *Committee Hansard*, 25 March 2013, pp. 21, 22.

25 Mr Tony McHugh, Manager and Principal Psychologist, Austin Health Psychological Trauma Recovery Service, *Committee Hansard*, 7 December 2012, p. 7.

26 Mrs Cheryl Hersey, Welfare Officer, Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 24.

## On-line support

- 9.30 Mr Ralph highlighted the importance of support organisations having an on-line internet presence, especially for the people associated with the current cohort of veterans.<sup>27</sup> This also aligns with DVA's assessment.
- 9.31 Likewise, DFA highlighted the importance of embracing social media to advise families of the wounded and injured on support services available to them, and of providing this information to families when a member is discharged from hospital.<sup>28</sup>

## Coordination

- 9.32 Associate Professor Malcolm Hopwood, the Clinical Director of PTRS, gave evidence that the contemporary veteran cohort, including Afghanistan, Iraq and East Timor and the various recent peace-keeping missions, do not generally have close links to the ex-service organisations. He advised that while there are some ex-service organisations specifically representing that group, there has not been a single body emerge with which the contemporary cohort identify. He believed that there will never be universal identification with a specific organisation and that it is unfortunate, because one of the purposes that the ex-service organisations serve is often as a pathway to support a veteran accessing mental health care and that that is a concern.
- 9.33 He gave evidence that a veteran is more likely to approach an organisation that 'culturally makes sense' to that individual and that for the contemporary veteran, 'the RSL's for older guys'.<sup>29</sup>
- 9.34 Soldier On's Executive Officer, Mr Simon Bloomer, told the Committee that interactions between ex-service organisations was cooperative and that there was no rivalry 'whatsoever'. He went on to note that Victoria appears to be far better served by such organisations than other states and that, particularly in Queensland but possibly also in other states, the RSL 'did more to fill the gaps'.<sup>30</sup>
- 9.35 DFA submitted that a common complaint from Defence families is that there are many departments and support services available and that as a
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27 Mr Tony Ralph, President, Brisbane Legacy, *Committee Hansard*, 7 December 2012, p. 21.

28 Defence Families of Australia, *Submission 8*, pp. 2-3.

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

30 Mr Simon Bloomer, Executive Officer Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 25.

result, family members often lack awareness and clarity regarding support structures. DFA advocated a single, recognisable service centre to coordinate health and social support services.<sup>31</sup>

- 9.36 Professor Sandy McFarlane AO told the Committee that the element that was missing in the national health care framework, particularly with respect to mental health, is a national 'commission of mental health' with oversight to critique and identify the adequacy of services. Professor McFarlane argued that the risks of neglecting the needs of current and ex-serving members of the Defence Force are magnified by the multiplicity of jurisdictions that are involved in their care.<sup>32</sup>
- 9.37 Associate Professor Susan Neuhaus CSC gave evidence that the provision of support for some individuals have fallen in the gaps between agencies rather than being appropriately managed across agencies. She echoed Professor McFarlane, believing that there is a need for a peak body or an advisory board with a governance framework that sits above the various support agencies to align and manage veteran support appropriately and to ensure that that the whole space is managed effectively.<sup>33</sup>

## Volunteerism

- 9.38 The Director of Carry On (Victoria), Mr Alistair Robb foreshadowed that perhaps in the not-so-distant future, because of the evolutionary nature of ex-service organisations, organisations like Carry On (Victoria) will eventually run out of people to run them because of the diminishing veteran community and that they may have to hire salaried staff to do the work of the current volunteers.<sup>34</sup>
- 9.39 Dr Glen Edwards submitted that volunteers are a much needed addition to services in assisting ADF and ex-service personnel, however they too need assistance.<sup>35</sup>

## Committee comment

- 9.40 All of these organisations do important and valuable work supporting the rehabilitation of ADF personnel wounded or injured on operations and
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31 Defence Families of Australia, *Submission 8*, p. 3.

32 Professor Alexander (Sandy) McFarlane AO, *Committee Hansard*, 8 February 2013, p. 1.

33 Associate Professor Susan Neuhaus CSC, *Committee Hansard*, 8 February 2013, p. 18.

34 Mr Alistair Robb, Director, Carry On (Victoria), *Committee Hansard*, 7 December 2012, p. 24.

35 Dr Glen Edwards, *Submission 34*, p. 2.

thanks them for their contribution to the Inquiry. The Committee extends its unreserved thanks to these organisations, and the broader support community, and recommends them to Australia's wounded and injured veterans.

- 9.41 The Committee notes that some organisations like Soldier On are de-conflicting with other agencies to ensure that there is no overlap between support organisations. The Committee remains concerned that not every support organisation is so diligent and believes that there is potentially a need for a representative council, peak body or an advisory board to increase visibility of effort and coordination between the various support agencies. The primary aim of such a body would be to identify service gaps.
- 9.42 The Committee feels that an undercurrent of volunteerism remains healthy in Australia, and with a new cohort of veterans, there will likely be an ongoing pool of volunteers, ex-servicemen or otherwise. The Committee encourages volunteerism but does not wish to impose Governmental restriction on the services provided by such organisations.

### **Recommendation 25**

**The Committee recommends that the Government commission an independent assessment of the need for, and establish if warranted, an appropriate national/state-based veterans' organisation coordination body.**

Senator Mark Furner  
Chair  
Defence Sub-Committee  
June 2013

Hon Joel Fitzgibbon MP  
Chair  
Joint Standing Committee on  
Foreign Affairs, Defence and Trade  
June 2013



## Appendix A – List of Submissions

1. Associate Professor Robert Atkinson, AM, RFD, FRACS, Brigadier (RTD)
2. Name Withheld
3. Dr Andrew Khoo
4. The Returned & Services League of Australia WA Branch Incorporated
5. Name Withheld
6. Name Withheld
7. Name Withheld
8. Defence Families of Australia
9. Name Withheld
10. Carry On (Victoria)
11. The Returned and Services League of Australia Ltd
12. Legacy Australia Council
13. The Hon. Jack Snelling MP
14. Name Withheld
15. Soldier On
16. Name Withheld
17. Department of Defence
18. Department of Veterans' Affairs
19. Assistant Secretary of Defense for Health Affairs, United States of America
20. Mr Geoff Parker
21. Centre for Military and Veterans' Health
22. Young Diggers
23. Australian Centre for Posttraumatic Mental Health
24. Austin Health
25. Vietnam Veteran's Federation
26. Dr Jean W Doherty MA BCh BAO
27. Vietnam Veterans Association of Australia Inc.
28. Centori Pty Ltd

29. Go2 Human Performance
30. Professor AC McFarlane AO
31. Dr Susan Neuhaus CSC
32. Dr Glen Edwards
33. Veteran's Health Advisory Council
34. Dr Glen Edwards (supplementary submission)
35. Soldier On (supplementary submission)
36. Trauma Release Australia
37. Department of Defence (supplementary submission)
38. Department of Defence (supplementary submission)
39. Australasian Care Services Network
40. Name Withheld
41. Department of Veterans' Affairs (supplementary submission)

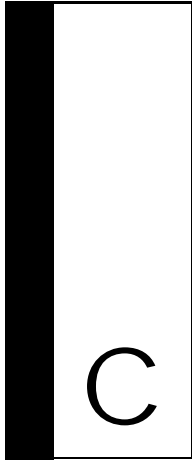




## Appendix B – List of Exhibits

1. Ms Melaine Pike - *Letter to Mr Ian Campbell PSM, Secretary, Department of Veteran's Affairs, August 2012.*
2. Austin Health's Psychological Trauma Recovery Service (PTRS) - *PowerPoint presentation, information sheet and PTRS Australian Defence Force Clinic fact sheet.*





## Appendix C – Witnesses who appeared at public hearings

Canberra, Tuesday 9 October 2012

### Department of Defence

Air Marshal Mark Binskin AO, Vice Chief of the Defence Force

Major General Angus Campbell DSC AM, Deputy Chief of Army

Major General Gerard Fogarty AO, Head, People Capability

Commodore Peter James Leavy, Director General, Navy People

Rear Admiral Robyn Walker AM, Commander, Joint Health, and Surgeon General ADF

### Department of Veterans' Affairs

Major General Elizabeth Cosson AM CSC, First Assistant Secretary, Client and Commemorations

Ms Judy Daniel, First Assistant Secretary, Health and Community Services

Mr Sean Farrelly, First Assistant Secretary, Rehabilitation and Support

**Darwin, Thursday 25 October 2012**

**Focus Groups with Wounded Soldiers, Robertson Barracks**

**Canberra, Tuesday 27 November 2012**

**Soldier On**

Lieutenant General (Retired) Peter Leahy AC, Chairman

**Melbourne, Friday 7 December 2012**

**Australian Centre for Posttraumatic Mental Health**

Professor David Forbes, Director

**Brisbane Legacy**

Mr Tony Ralph, President

**Carry On (Victoria)**

Mr Simon Bloomer, Executive Officer

Mrs Cheryl Hersey, Welfare Officer

Mr Alistair Robb, Director

**Psychological Trauma Recovery Service**

Associate Professor Malcolm Hopwood, Clinical Director

Mr Tony McHugh, Manager and Principal Psychological

**Canberra, Tuesday 5 February 2013**

Major General (Retired) John Cantwell AO DSC

## **Adelaide, Friday 8 February 2013**

Associate Professor Robert Atkinson AM RFD

Dr Glen David Edwards

Sergeant Craig Hansen, Member, 7th Battalion, Royal Australian Regiment

Professor Alexander McFarlane AO

Associate Professor Susan Neuhaus CSC

Mr Michael Gunther Baron non Berg MC, Veterans Advisory Council of South Australia

## **Canberra, Tuesday 12 March 2013**

### **Defence Families of Australia**

Ms Julie Anne Blackburn, National Convenor

### **Returned and Services League of Australia Ltd**

Rear Admiral (Retired) Ken Doolan AO, RAN, National President

Mr Terence John Meehan, State President, Queensland Branch

## **Canberra, Tuesday 19 March 2013**

### **Department of Defence**

Air Marshal Mark Binskin AO, Vice Chief of the Defence Force

Major General Angus Campbell DSC AM, Deputy Chief of Army

Major General (Retired) Dave Chalmers AO CSC, First Assistant Secretary, Client and Commemorations Division

Major General Gerard Fogarty AO, Head, People Capability Division, Defence People Group

Commodore Peter Laver, Director-General Navy People

Air Commodore Robert Rodgers CSM, Director-General Personnel – Air Force

Rear Admiral Robyn Walker AM, Commander Joint Health

### Department of Veterans' Affairs

Ms Judy Daniel, First Assistant Secretary, Health and Community Services  
Division

Mr Sean Farrelly, First Assistant Secretary, Rehabilitation and Support Division

Ms Veronica Hancock, Assistant Secretary, Mental and Social Health Branch

Dr Graeme Killer AO, Principal Medical Advisor

Mr Wayne Penniall, National Manager, Veterans and Veterans Families  
Counselling Service

### **Brisbane, Monday 25 March 2013**

#### Australian Defence Force

Lieutenant Colonel Michael Charles Reade, Professor of Military Medicine and  
Surgery, Joint Health Command

#### Centori Pty Ltd

Mr Brian Freeman, Director

#### Go2 Human Performance

Mr Roderick Martin, Director

#### Toowong Private Hospital

Dr Andrew Khoo, Clinical Director, Group Therapy Day Programs

#### Young Diggers Australia

Mr Mervyn John Jarrett, President

### **Brisbane, Tuesday 26 March 2013**

#### Focus Groups with Wounded Soldiers, Soldier Recovery Centre, Gallipoli Barracks, Enoggera



## Appendix D – ADF Personnel deployed to Afghanistan killed in action

As of 24 June 2013, there have been 40 operational deaths in Afghanistan. Soldiers killed in action have been:<sup>1</sup>

- Sergeant Andrew Russell, SASR, died of wounds sustained when his patrol vehicle struck an anti-tank mine on 16 February 2002.
- Trooper David Pearce, 2/14 LHR QMI, was killed when his ASLAV was struck by an Improvised Explosive Device on 8 October 2007.
- Sergeant Matthew Locke, SASR, was killed by Taliban insurgent small-arms fire on 25 October 2007.
- Private Luke Worsley, 4RAR (Cdo), was killed by Taliban insurgent small-arms fire on 23 November 2007.
- Lance Corporal Jason Marks, 4RAR (Cdo), was killed by Taliban insurgent small-arms fire on 27 April 2008.
- Signaller Sean McCarthy, SASR, was killed when the vehicle he was travelling in was struck by an Improvised Explosive Device on 8 July 2008.
- Lieutenant Michael Fussell, 4RAR (Cdo), was killed by an Improvised Explosive Device during a dismounted patrol on 27 November 2008.
- Private Gregory Sher, 1st Commando Regiment, was killed in a rocket attack on 4 January 2009.
- Corporal Mathew Hopkins, 7th Battalion, The Royal Australian Regiment, was killed during an engagement with the Taliban on 16 March 2009.

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<sup>1</sup> Department of Defence, viewed 24 June 2013, <[www.defence.gov.au/op/afghanistan/info/personnel.htm](http://www.defence.gov.au/op/afghanistan/info/personnel.htm)>.

- Sergeant Brett Till, Incident Response Regiment, was killed by an Improvised Explosive Device during a route clearance task on the 19 March 2009.
- Private Benjamin Ranaudo, 1st Battalion, The Royal Australian Regiment was killed as a result of an Improvised Explosive Device on 18 July 2009.
- Sapper Jacob Moerland, 2nd Combat Engineer Regiment was killed as a result of an Improvised Explosive Device strike on 7 June 2010.
- Sapper Darren Smith, 2nd Combat Engineer Regiment died of wounds sustained during an Improvised Explosive Device strike on 7 June 2010.
- Private Timothy Aplin, 2nd Commando Regiment died as a result of a helicopter crash on 21 June 2010.
- Private Scott Palmer, 2nd Commando Regiment died as a result of a helicopter crash on 21 June 2010.
- Private Benjamin Chuck, 2nd Commando Regiment died of wounds sustained in a helicopter crash on 21 June 2010.
- Private Nathan Bewes, 6th Battalion, The Royal Australian Regiment was killed as a result of an Improvised Explosive Device on 9 July 2010.
- Trooper Jason Brown, SASR, died as a result of gunshot wounds sustained in an engagement with insurgents on 13 August 2010.
- Private Tomas Dale, 6th Battalion, The Royal Australian Regiment was killed as a result of an Improvised Explosive Device strike on 20 August 2010.
- Private Grant Kirby, 6th Battalion, The Royal Australian Regiment was killed as a result of an Improvised Explosive Device strike on 20 August 2010.
- Lance Corporal Jared MacKinney, 6th Battalion, The Royal Australian Regiment, was killed during an engagement with insurgents on 24 August 2010.
- Corporal Richard Atkinson, 1st Combat Engineer Regiment, was killed as a result of an Improvised Explosive Device strike on 2 February 2011.
- Sapper Jamie Larcombe, 1st Combat Engineer Regiment, was killed during an engagement with insurgents on 19 February 2011.
- Sergeant Brett Wood, MG, DSM, 2nd Commando Regiment, was killed by an Improvised Explosive Device during a dismounted patrol on 23 May 2011.
- Lance Corporal Andrew Jones, 9th Force Support Battalion, died of wounds as a result of a small-arms fire incident on 30 May 2011.



- Lieutenant Marcus Case, 6th Aviation Regiment, died of wounds sustained in a helicopter crash on 30 May 2011.
- Sapper Rowan Robinson, Incident Response Regiment, died as a result of gunshot wounds sustained in an engagement with insurgents on 06 June 2011.
- Sergeant Todd Langley, 2nd Commando Regiment, was killed during an engagement with insurgents on 4 July 2011
- Private Matthew Lambert, 2nd Battalion, The Royal Australian Regiment, died of wounds as a result of an Improvised Explosive Device strike on 22 August 2011.
- Captain Bryce Duffy, 4th Regiment, Royal Australian Artillery, was killed as a result of a small-arms incident on 29 October 2011.
- Corporal Ashley Birt, 6th Engineer Support Regiment, was killed as a result of a small-arms incident on 29 October 2011.
- Lance Corporal Luke Gavin, 2nd Battalion, The Royal Australian Regiment died of wounds as a result of a small-arms incident on 29 October 2011.
- Sergeant Blaine Flower Diddams MG from the Special Air Service Regiment was killed during a small arms engagement with insurgents on 02 July 2012.
- Sapper James Martin, 2nd Combat Engineer Regiment was killed as a result of a small-arms incident on 29 August 2012.
- Lance Corporal Stjepan Milosevic, 2nd/14th Light Horse Regiment (QMI), was killed as a result of a small-arms incident on 29 August 2012.
- Private Robert Poate, 6th Battalion, the Royal Australian Regiment was killed as a result of a small-arms incident on 29 August 2012.
- Private Nathanael Galagher, 2nd Commando Regiment, was killed in a helicopter crash on 30 August 2012.
- Lance Corporal Mervyn McDonald, 2nd Commando Regiment was killed in a helicopter crash on 30 August 2012.
- Corporal Scott Smith, Special Operations Engineer Regiment, was killed as a result of an Improvised Explosive Device on 21 October 2012.
- Corporal Cameron Stewart Baird MG, 2nd Commando Regiment, was killed by small arms fire during an engagement with insurgents on 22 June 2013.

Lest we forget.