Submission No 12

Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Name: Charlies M Wright
Chairman

Organisation: Legacy Australia Council

10 August 2012

Mr Jerome Brown
The Secretary
Joint Standing Committee on
Foreign Affairs, Defence and Trade
PO Box 6021
Parliament House
Canberra ACT 2600

Email:jscfadt@aph.gov.au

Dear Sir,

Inquiry into the Care of ADF Personnel, Wounded and Injured on Operations

Please find attached Legacy Australia Council Inc submission to the above Inquiry.

Should the committee seek any further information or for a Legacy Representative to attend a committee hearing or meeting, please contact the undersigned to make arrangements.

Yours sincerely,

Charles M Wright
Chairman

Encl.

Legacy Australia Council

293 Swanston Street, Melbourne VIC 3000
Box 368 GPO, Melbourne, Vic, 3001
Phone: (03) 8626 0590 Fax: (03) 9662 9363
Email: legacycouncil@bigpond.com.au
www.legacy.com.au
ABN: 59 203 621 448

Legacy Australia Council

Submission to the

Defence Sub-Committee
of the
Joint Standing Committee for Foreign Affairs, Defence and Trade

Inquiry into the Care of ADF Personnel Wounded and Injured on Operations

Thank you for the invitation to make a submission to the Inquiry into the Care of ADF Personnel Wounded and Injured on Operations by the Defence Sub-Committee of the Joint Standing Committee for Foreign Affairs, Defence and Trade, vide your letter dated 27 June 2012.

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. Annex A provides a summary of the role of Legacy under the headings of Purpose, Methods and Outcomes.

Terms of Reference and the Legacy Submission

Based upon the Terms of Reference, the Legacy submission will limit its response to addressing those matters as they impact on the families of incapacitated veterans. ie TOR paragraphs:

(c) Care of wounded and injured ADF personnel on return to Australia, including ongoing health, welfare and rehabilitation support arrangements.

(e) Management of personnel who cannot return to ADF service including:

(ii) Transition from ADF managed health care to DVA managed health care and support,

(iii) Ongoing health care and support post transition from the ADF

Legacy Experience

The Legacy response draws upon a history of supporting *the dependants of comrades who gave their lives or health in the Great War,* and subsequently in other wars and forms of operational service. Since the 1960s Legacy has focused its care for the families of deceased veterans, and only recently returning its attention to include the families of incapacitated veterans. Legacy participated in the 2011 Chief of Army's Wounded Diggers Forum (including lead up workshops), and has begun to take an active approach to support families of incapacitated veterans while they are still in the ADF or recently discharged. In addition Legacy draws upon academic research it is commissioning in this field and the early focus groups that have been conducted in the early phase of this research. There is also recent experience where Legacy in Brisbane is collaborating with the ADF, through the Enoggera based Soldier Recovery Centre, to support the families of incapacitated veterans.

While the Legacy experience in supporting the families of incapacitated veterans in recent years is not substantial, it has been instructive and provides a number of insights that Legacy believes are worth recording for the benefit of this Inquiry.

Clarifications

Veteran: Legacy uses the term 'veteran' to describe any current or former member of the ADF with operational service.

Incapacitation: Legacy's support to the families of incapacitated veterans is on the basis of the impact of the veteran's incapacitation on the family. That is Legacy will assist a family when the veteran is incapable of managing the affairs and welfare of their family. Or perhaps better expressed as "Legacy will assist a family being impacted by a veteran's incapacitation."

The family would only receive Legacy support if they agree to being supported by Legacy.
Legacy continues to offer support to the widow/widower and dependants of all deceased veterans.

Wounds and Injuries: Legacy considers both physical and mental health wounds and injuries to be in the scope of this inquiry into the Care of ADF Personnel Wounded and Injured on Operations.
Legacy also acknowledges attempts (particularly the Canadian Veterans Affairs Department) to introduce terminology to normalise mental health conditions, reduce stigma and assist veterans in attitudinal barriers to seeking treatment.

Key Issues

- Supportive and supported families are an important element to treatment and recovery.
- Continuity of care is critical but is at risk given organisational discontinuity of support between the Department of Defence and the Department of Veteran Affairs.
- Mental Health support .

Families' role in treatment and recovery

Desired Outcome:

- Family role to be recognized, acknowledged, communicated and supported.

Discussion:

Direct feedback at the Chief of Army's 2011 Wounded Diggers Forum and at the Legacy commissioned research focus groups with partners of veterans, have reinforced the need to recognise the role of families in the treatment and rehabilitation pathway of the wounded and injured. Families, but in particular partners, often become the point of contact and continuity for decision making on behalf of very seriously wounded/injured veterans. When there is significant incapacitation the partner/family often become the key support person (carer) during treatment, and in the worst cases they become the default case manager for the veteran covering for the gaps in support from Defence and DVA. Partners/families also are key sources of motivation and encouragement for the incapacitated veteran to work through their treatment and rehabilitation toward recovery.

Families often appear to have little awareness of the treatment and rehabilitation processes. Families reported their role, while being critical and often covering for any treatment and rehabilitation inadequacies, was perceived by them not to be recognised by Defence and DVA. Thus some effort should be taken to acknowledge the role of the partner/family in the treatment and rehabilitation of the veteran. Further, direct communication with the partner/families should be established to explain not

only treatment and rehabilitation, but also the importance (and value) of their support role is in the recovery of an incapacitated veteran. Given the role partners/families play in the treatment and rehabilitation, Defence and DVA should consider how support can be provided for partners/families in their support role.

Recommendations for consideration by Defence and DVA

- Recognise the role of partners/families in the treatment and rehabilitation of wounded/injured veterans.
- Establish an appropriate means of acknowledging the partners/families in the treatment and rehabilitation of wounded/injured veterans.
- Establish inclusive and direct communications (with appropriate Privacy protocols) with the partners/families in the treatment and rehabilitation of wounded/injured veterans.
- Develop methods and resources to support the partners/families in the treatment and rehabilitation of wounded/injured veterans.

Continuity of care is critical but is at risk given organisational discontinuity of support

Desired Outcomes:

- Awareness of risk to continuity of care through acknowledgement of the discontinuity of support as a veteran's care transitions between two Departments, Defence and Veteran Affairs.
- Active mitigation of risk to continuity of care for veterans who cannot return to ADF service.

Discussion:

For the management of personnel who cannot return to ADF service, there is an organisational discontinuity in authority, responsibility, accountability, budget, resources, systems and processes, that put at significant risk the achievement of continuity of care for wounded/injured veterans.

There exists an organizational gap in the continuity of care for wounded and injured personnel. The organizational gap is the boundary between the Departments of Defence and Veteran Affairs. Unless the boundaries overlap, by definition there will be a gap, or at a minimum some form of discontinuity. The lead government Department responsible for health support for wounded and injured veterans transitions from Defence to DVA. In the veteran's transition between the two organizations, the gap is in affect the space/discontinuity between the two separate Departments, with two separate Department heads, responsible for two separate budgets, working within different legislative frameworks (ie different Acts of Parliament), with, up until recent years, two separate Ministers.
Such an organisational structure makes very difficult the achievement of unity of effort, to achieve continuity of care and support.
Thus with such strategic design limitations special awareness and consideration of this organisational gap are required.

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.

Defence and DVA are to be applauded for recent initiatives to begin to mitigate the risks of discontinuity that includes the establishment of a DVA On Base Advisory Service, and the Joint eHealth Data and Information (JeHDI) Project.

Recommendations for the Prime Minister and Cabinet

- Maintain awareness of risk to continuity of care through acknowledgement of the organisational discontinuity of support between Defence and DVA
- Continue to appoint a single Minister for Defence Personnel and Veterans' Affairs.

Recommendation for the current Minister for Defence Science and Personnel and Minister for Veterans' Affairs.

- Enhance active mitigation of risk to continuity of care for veterans who cannot return to ADF service. For example provide mechanisms where veterans undergoing treatment who cannot continue in Defence, receive continuity of care and are provided the option of not changing treating medical practitioners, particularly those providing mental health treatment.

Mental Health support

Desired Outcomes:

- Evaluating value of introducing normalising terminology to describe battlefield and operational caused Mental Health conditions.
- Resourcing capabilities to increase capacity to deal with increased mental health prevalence rates.

Discussion:

Mental health issues are likely to be unmasked amongst large numbers of younger veterans still servicing in the ADF once deployment rotation opportunities are perceived to become very limited, and\or these veterans leave the ADF. Current mental health prevalence rates are likely to rise sharply in the coming years.

Of the families of incapacitated veterans referred by the Enoggera Soldier Recovery Centre to Brisbane Legacy, regardless of the type of wound/injury, there is a very high proportion of these veterans who also have significant mental health issues [the exact number has not been disclosed to protect medical in-confidence information about these veterans].

Defence and former Defence families are the Australian demographic group that is least likely to seek mental health support when they need it (Dr Brian O'Toole: Anzac Research Institute). Defence and DVA will need to understand and find ways to overcome what is likely to be both attitudinal and knowledge barriers.

Overcoming the stigma associated with mental health issues, and normalizing both the existence and treatment of mental health needs to be addressed. Legacy notes there have been attempts (Canadian DVA) to characterise mental health issues not as a disorder (eg PTSD), but as a battlefield wound or operational injury (Operational Stress Injury - OSI). Such an approach in terminology helps to normalize mental health wounds and injuries as part of battle, and is perceived as more honourable and easier to accept than something termed as a 'disorder'.

The stigma and normalising issues are significant in assisting families to convince their veteran partner to seek treatment and support as required. Defence and DVA should investigate the potential benefits for introducing terminology for dealing with mental issues that help reduce stigma and normalize mental health issues and the treatment. There will be arguments from clinical mental health practitioners and researches that 'disorder' is the most accurate medical condition definition. However a research study is

required to investigate the value of introducing normalising terminology (such as 'Battlefield Stress Wound', or 'Operational Stress Injury', as general/common usage descriptors, while not replacing clinical medical definitions.

If not managed appropriately, in the worst case mental health issues could manifest themselves as suicides. In the US the numbers of veteran suicides has reached a level of 6500 per year (18/day).

A veteran's mental health issues impact on the family and there is a body of study on the inter-generational effect of a veterans mental health, including the higher rate of suicide among the children of veterans. Defence is to be commended for its Battle Smart and Family Smart programs, however more resources are required to provide resilience development pre-deployment and to provide early intervention post deployment, both of which should include partners and families.

As the evidence and knowledge builds about the rates of delayed on set of mental health issues, work is required to understand the levels of resourcing required to support the nation's fourth generation of young veterans as the prevalence rates inevitable rise over the next decade.
If not resourced, the impact on families will be significant in both the short term, but also in the long term with intergenerational impacts.

Recommendations for consideration by Defence and DVA

- Instigate research into evaluating the benefits of introducing normalising terminology for describing battlefield and operational caused mental health conditions.
- Apply more resources to provide resilience development pre-deployment and to provide early intervention post deployment, both of which should include partners and families.
- Acknowledge delayed onset of mental health issues.
- Acknowledge likely increase in mental health prevalence rates.
- Commence resourcing capabilities to increase capacity to deal with increased mental health prevalence rates.

Prepared by: CEO Sydney Legacy
Consulted: CEO Brisbane Legacy
Released by: Chairman Legacy Australia Council

Annex A

Legacy Care

Purpose: The care of dependants of those who served their country; namely veterans who died (or incapacitated) on operational service or subsequently, and
Australian Defence Force personnel who died as a result of their service, affords a field for service.

Methods:

- Contact and Communication
    - Visits/phone calls
    - Newsletters/Magazines
    - Social Media
- Mentors for children
- Pension advocacy
- Social Support (Peer Support)
- Widows Clubs / Friendship Groups
- Respite
    - Holidays
- Welfare Support (includes Community Service Worker referrals)
- Financial Support
- Education Support
- Youth Development

Outcomes for Widows/partners and dependants:

- A sense of support available if required (back-up, safety net).
- Receive their government entitlements and able access to funded services when required.
- Financial assistance provided when in necessitous circumstances.
- Maintain dignity, be resilient, be able to be independent and exercise choice.
- A valued and contributing member of Australian society and the local community.