7

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.[1]

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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.[2]

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).[3]

7.7 The Committee shares Professor McFarlane's concerns and recommends that post-deployment syndromes be the subject of further study.

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

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.[4]

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.[5]

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.[6]

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.[7]

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.

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.[8] 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.[9]

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.[10]

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.[11] 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'.[12]

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.[13]

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.[14]

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.[15] '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.

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.[16]

7.20 Pre-deployment psychological preparation briefs are given and cover topics such as separation, cultural adaptation, operational tempo, fatigue, stress management and homecoming.[17] 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.[18]

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.[19]

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.[20]

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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.[21]

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.[22]

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.[23] The ACPMH submitted that the implementation of the RtAPS/POPS process is a critically important initiative.[24] 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.[25]

7.27 Another soldier commented that 'It's a joke'![26]

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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.[27] In another instance, a member was able to conceal psychological issues and the POPS interview was conducted as a mere formality.[28] 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.[29]

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.[30]

7.30 Defence submitted that ADF personnel are not to redeploy on any further operation until such time as any outstanding post deployment heath assessments and POPS screening has been undertaken.[31] 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.[32] 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.[33]

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.[34]

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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.[35] Defence Families of Australia (DFA) also submitted that such a post-deployment process needed to be considered.[36]

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.[37]

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.[38]

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.[39] 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.[40]

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.[41]

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.[42] 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.[43] '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.[44]

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.[45]

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.[46]

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*.[47]

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.

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.[48]

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.[49] 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.[50]

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.[51]

7.49 The Returned and Services League of Australia (RSL) South Australia Branch submitted that the development of additional support services for

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.[52]

> 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.[53]

7.50 The Committee heard that PTSD can lie dormant for up to 30 or 40 years.[54] 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.[55]

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.[56]

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.[57]

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.[58]

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.[59]

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'.[60] 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.[61]

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

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.[62] 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.[63]

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.[64]

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.[65] DFA also highlighted that this is a common concern with families.[66]

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'.[67]

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.[68]

Committee comment

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

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 or 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.[69] 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.[70]

7.68 The Committee heard evidence that during pre- and post-deployment health checks, physical injures 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.

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.