Submission No 5

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

Name: **Withheld**

Care of ADF Personnel Inquiry

Thursday, 2 August 2012

The Secretary
Joint Standing Committee on Foreign Affairs, Defence and Trade
House of Representatives
Parliament House
Canberra ACT 2600

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

Dear Sir,

I wish to make the following submission to your inquiry.

My brief submission will focus on Terms of Reference (c) and partly on (e) (ii) (iii).

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. My wife has since ceased work to support me. We have recently been through the harrowing process of seeking (and eventually receiving) assistance from DVA. This experience has provided an insight into a number of aspects that I feel are relevant to this inquiry.

Those aspects include:

1. **Recognition and reversal of the learned aggression arising from military training**
2. **Recognition of the role of combat trauma on memory and its implications for contracting PTSD**
3. **Recognition of a duty of care to veterans who may be at risk of suffering from effects of PTSD**
4. **Recognition of a duty of care to current and future partners and children of veterans**
5. **DVA performance standards compared to their published commitments to quality service**
6. **Review of Ex Service Organisation system of providing access pathways to DVA assistance**

I trust that you will see fit to include this submission in your inquiry and wish the Committee well in its deliberations.

Your faithfully,

TOR (c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements:

1. Recognition and reversal of the learned aggression arising from military training

For many years the military has used certain training methods to prepare personnel to become part of a fighting force that will operate effectively and efficiently in a stressful situation such as a war zone. In essence the training overrides the normal flight-freeze-fight response to reprogram the soldier to fight.

Nic Fothergill in the VVCS (2001) DVD observes that all Australian veterans, irrespective of their final job within the services, are subjected to the same basic training. Tasks are learned by repetition (drills) and reinforced by the use of rewards or punishment. He then describes how the military train personnel to activate the fight response with so that personnel will instinctively react with discipline and in unison. He notes that unfortunately this training may shape inappropriate or unhelpful responses to stress in civilian life. Fothergill adds that this inappropriate aggression usually harms both the veteran and their families by damaging relationships and their support.

The trained aggression is compounded by the consequences of experiencing trauma in a war zone. This has been highlighted in The Weekend Australian (July 28-29, 2012, World page 11) in an article that links the trauma of war to domestic violence. It reports a new study of 13,000 veterans of Iraq and Afghanistan which found that one in eight British soldiers has attacked someone after coming home from fighting. The study found there was a link between combat and trauma, and violence at home, often directed at their partners. A third of the victims were someone in the family, often a wife or girlfriend. The study also found that soldiers who had seen more than one traumatic event were more likely to report being violent.

On reflection I spent almost 30 weeks training for Vietnam (ie being programmed for war) yet only 2 hours was devoted to my discharge from the Army and preparation for return to civilian life. No attempt was made to deprogram my military induced fight readiness. I was sent back to resume my civilian life, not realising that I would have a tendency to act in a far more aggressive manner than I had prior to service. No warnings were given as to what this may mean in later life.

It is recommended that research be conducted to establish the means to allow reversal of the initial training so as to deprogram combat personnel on returning from a combat zone. In addition, suitable mechanisms should be developed to provide ongoing support to assist demobilised personnel with problems arising from this conditioning.

TOR (c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements:

2. Recognition of the role of combat trauma on memory and its implications for contracting PTSD

There are a number of authors who have reported on the impact of trauma on combat personnel and the link to PTSD including Siegel (2009) and Scott (2001). Siegel explains that the intense traumatic conditions found in a war zone disrupt the normal processes of the brain including the process of laying down memories. Under normal conditions the hippocampus acts like a librarian to assist with storage and retrieval of memories (and has the capacity to ascribe a sense of time and place to individual memories).

Many veterans suffer from flashbacks. Under highly stressful conditions such as fear, helplessness or horror, Seigel notes that the flight-fight-freeze response floods the body with Cortisol. This blocks the librarian function of the hippocampus and disrupts the memory storage process. As a result, the veteran can be left with dangling or unresolved traumatic memories, stored randomly in their brain. These can later cause intrusive thoughts and flashbacks - long after leaving the war zone.

At the time of the original trauma, the amygdala causes high levels of adrenaline to be released. The high levels of adrenaline sear into the implicit memories, along with traces of the original trauma experience (feelings of terror, details of the event and behavioural reactions). (Seigel, 2009)

These unresolved memories are stored randomly as fragments of emotionally charged memories. They remain free floating in the brain, but are not under the control of the librarian and have the capacity to cause flashbacks. These flashbacks are disturbing as they create a sense of re-experiencing a very real traumatic experience, without registering that this is an unresolved memory from the past. For many veterans they appear to be occurring in real time.

It is recommended that ADF develop a mechanism of screening for PTSD for returning personnel to assist in early identification and early intervention with this mental health condition. As part of this process, all returning personnel should be provided with comprehensive education regarding PTSD. The intended outcome of these approaches should be to forewarn veterans (and their partners) and at the same time mitigate some of the effects of PTSD, thereby avoiding or minimising some of the distress that can arise in later life.

TOR (c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements:

3. Recognition of a duty of care to veterans who may be at risk of suffering from effects of PTSD

Contemporary legislation places a duty of care on employers to provide a safe working environment for their employees. While that may not be possible in a war zone, it certainly is within a peace time environment particularly for demobilised military personnel. It would be reasonable to assume that the same standards apply to ADF and DVA in managing the health and well being of returning personnel and post discharge veterans (and their families). This is particularly relevant where war/work related injuries such as PTSD can be anticipated in advance.

There is considerable evidence regarding the extent of PTSD in the veteran community. Based on this existing data it is possible to predict the likely number of returning personnel who can be expected to develop PTSD, along with a range of associated mental health disorders such as anxiety, depression, insomnia and alcohol or drug abuse.

In 1999 DVA surveyed the health of 50,000 Vietnam Veterans: 40,000 reported as follows:-

• PTSD	31%	Anxiety Disorder	41%
• Depression	45%	Insomnia/Sleep Disturbance	52%
• Hearing	55%	Alcohol/Drug Abuse	36%
• Allergies	21%	Tinea	20%
• Cancer	25%	Dermatitis	19%
• Heart Disease	15%	Eczma	6%

While these rates were self reported by veterans, they did not represent conditions that had been 'accepted' by DVA at the time. More recently published data from DVA, (2011), reveals that 17,454 (29%) of Vietnam veterans have actually been 'accepted' as having war related PTSD - based on the Nominal Role of Vietnam Veterans (DVA, 2012). The actual number with PTSD may be higher due to those who have suicided, not applied, or applied and been rejected.

These lessons from Vietnam have relevance to the current insurgent style warfare that many of our military personnel are being exposed to currently. It seems reasonable to anticipate that similar statistics can be expected for current serving and returning personnel. That is on the balance of probability one can anticipate that around 30% will be affected by PTSD either during, or at some stage following, their period of active service.

This has implications for the duty of care carried by ADF and DVA in securing the welfare of its past, present and future workers (service men and women). A comprehensive and proactive strategy is needed to aid with early identification, intervention and treatment strategies, not only for PTSD but also the other associated mental health issues such as depression. For example, VVCS (c1992) observed that around 50% of people with chronic PTSD have depression.

The outlook for returning personnel and veterans with PTSD is potentially fatal. Matthew Tull (undated) reports that people with PTSD are at a greater risk to attempt suicide. He describes a study which found that 27% of people with PTSD had attempted suicide at some point in their lifetime. He goes on to say that there have been reports of high rates of suicide among returning US soldiers from Iraq and Afghanistan. Tull refers to a US DVA study of 500,000 US veterans which found that former active duty veterans and veterans who had a psychiatric disorder were at greater risk for suicide.

A number of recent reports have highlighted the incidence of suicide in returning veterans. Mark Thompson (2009) in Time Magazine quotes US General Peter Chiarelli :"...Soldiers who are suffering from posttraumatic stress are six time more likely to commit suicide that those that are not." He added that "...the greatest single debilitating injury of soldiers returning from Iraq and Afghanistan is posttraumatic stress." The article states that 1 in 5 soldiers return home reporting symptoms of PTSD.

These observations take no account of the delayed onset aspect of PTSD. In my case it was 40 years after serving. In a small sample of Vietnam veteran colleagues we have variously lasted from 25 to 40 years after serving, before we 'hit the wall' and were diagnosed with PTSD. It seems that each individual has a different level of resilience and this influences how long before we succumb – if at all. The delayed onset aspect of PTSD is consistent with Fothergill's view - that it is only a matter of time before those unresolved traumas will resurface and emerge as late onset chronic PTSD.

It is recommended that ADF and DVA review policies and procedures in regard to securing the welfare of past, present and future workers (service men and women) particularly with regard to PTSD and associated mental health issues. The review should look at developing a proactive strategy to enable early identification, intervention and treatment for current and returning personnel and veterans. The emotional, relationship and financial implications of delayed onset PTSD should be taken into account when developing support measures for post service veterans.

TOR (c) care of wounded and injured personnel on return to Australia, including ongoing health, welfare, and rehabilitation support arrangements:

4. Recognition of a duty of care to current and future partners and children of veterans

ADF and DVA have a duty of care to partners and children of current serving personnel and veterans. There is sufficient evidence to show that poor mental health in veterans has a detrimental flow on effect to partners and children. DVA (1999) published a self reporting study into Vietnam Veterans Health. Part C of this survey examined the effect of veteran health on the health of partners.

The study found that 36% of veterans reported that service in Vietnam, or health problems arising as a consequence of their service in Vietnam, have had a serious adverse effect on current or past partners. Some 40% reported physical or psychological health problems in their partners that they felt were related to their Vietnam service. The most common conditions in partners were cited as:

- Stress (40%),
- anxiety (34%) and
- depression (30%)

Thirty-nine percent (39%) of all veterans with partners reported that treatment has been required for these conditions. Those with greater length of service in Vietnam reported higher levels of problems.

These finding are consistent with the writer's personal experience. In each household (including my own) where there is a Vietnam Veteran with mental health issues (eg PTSD, depression, anxiety, insomnia, tinnitus, etc), there has been evidence of corresponding stress related health issues for the partners. For example, since being diagnosed with PTSD, my partner has suffered from chest pains, skin rashes and a range of digestive disorders and food allergies. She feels constantly distressed by events including my sudden collapse, loss of independence, financial insecurity and relationship challenges. She struggles daily with the fact that I have undergone a personality change and tend to be quiet, angry and depressed. She mourns for the easy going, happy person she married 40 years ago.

The DVA (1999) study also examined the impact of veteran health on congenital abnormalities and deaths amongst children of veterans. Based on the Australian community standard, suicide shows the most substantial difference, with the number of veterans' children committing suicide 3 times as high as expected. Deaths from accident/other causes were approximately 1.6 times as high as expected based on the Australian community standard, and deaths from illness were 1.1 times higher than expected.

These disturbing findings have implications for current serving personnel and veterans of all ages who fall under the care of DVA.

It is recommended that resources be directed to 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. Efforts should be undertaken to educate the veteran community and ensure that these services are promoted to all members, including partners and children.

TOR (e) management of personnel who cannot return to ADF service including:
(iii) ongoing health care and support post transition from the ADF

5. DVA performance standards compared to their published commitments to quality service

DVA publishes a set of commitments that are intended to provide quality service (presumably to its veteran customers). As a recent and current consumer of the DVA service, my impressions have been one of a very 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. There is a common view amongst veterans that DVA officers seem wary of dealing directly with veterans and would prefer not to have to meet with them face-to-face.

When considering claims for assistance there is a perception that DVA has adopted a stance similar to many insurance companies and will seek to deny or downgrade a claim in the first instance. In some instances, claims can become bogged down in a lengthy appeals process and in some cases drag on for more than a year. During this protracted process the veteran and partner are often at wits end and may be experiencing financial difficulty. The cynical view is that DVA deliberately drag the process out in the hope of discouraging the applicant from persisting.

In 1987 at the Welcome Home parade in Canberra, Mike Towers attended his 4 RAR Battalion reunion. He conducted a simple survey amongst 100 veterans who had previously sought assistance from DVA for a range of conditions. Of 98 responses, he recorded that 18 were partially or fully accepted. Eighty claims were rejected by DVA. Of those 80 rejected only 34 had appealed. The remaining 46 veterans became 'disillusioned and gave up in disgust, feeling further alienated by politicians and bureaucrats'. Given the earlier observations regarding suicide, it is important to recognise that some veterans who have been rejected may choose to take their own life.

One would hope that the acceptance rate has improved since 1987. In keeping with contemporary practice it would seem appropriate for DVA to develop and adopt a set of Key Performance Indicators that include measures of timeliness in responding to client claims. These measures should take account of the role played by the outsourcing of the application process to Ex Service Organisations. See section 6, below.

It is recommended that a review of processing times and success rates be undertaken for claims of assistance to DVA. In addition, a comprehensive set of key performance indicators should be developed against which to monitor the ongoing performance of individual DVA officers when dealing with claims. These KPI should include target processing times, client reporting arrangements. Provision should be made to seek and allow client feedback regarding client interaction with DVA.

TOR (e) management of personnel who cannot return to ADF service including:
(iii) ongoing health care and support post transition from the ADF

7. Review of Ex Service Organisation system of providing access pathways to DVA assistance

Following my breakdown, it was suggested that my sudden illness could be from my prior war service. As a result, I contacted the Veterans and Veterans families Counselling Service (VVCS). A Counsellor confirmed that my symptoms were typical of a Vietnam Veteran and advised me to contact a Pension Officer, or Advocate, at one of the local Ex Service Organisations. I duly contacted one of the local ESOs (in this case Vietnam Veterans Association of Australia) and was assigned an Advocate who submitted a claim to DVA, on my behalf. I discovered that these officers are typically volunteers - usually veterans – who are suffering from the effects of PTSD and other mental health issues themselves. They are typically receiving a pension and have a genuine desire to help other veterans and give something back to the community.

It seems that DVA uses the ESOs as part of an outsourcing arrangement in respect of making claims for assistance by veterans. DVA provides training for these officers and appear to use them as a buffer between itself and the veteran. While each officer and advocate appears well intentioned, there seems to be some variability in standards of performance. There also appears to be deficit of counselling skills within this group.

A simple survey amongst fellow veterans (from several different States using different ESOs) confirms the variability in the level of service and range of difficulties in the claims process. All reported that the process to be complex, opaque and stressful. In many cases there were problems that appeared to be due to errors or omissions made by the advocate. Many found it necessary to change advocates in order to have overcome the problems created from the first attempt.
Each setback in the application process compounds the level of agitation, frustration and distress within the veteran household for the veteran and partner - who are simultaneously struggling with mental health, relationship, work related and financial issues.

Nic Fothergill (VVCS, 2001) recommends that veterans seeking to help others should fix themselves first. That way they are in a better state to support and guide others. The current process of selection for training may not take this into account. Some veteran officers are struggling with personal health issues which tend to make the situation worse, particularly for the newly identified veteran. In my case I had some spectacular rows with my advocate when my intolerant and unstable mental state collided with his communication deficiencies. My wife observed that I would become very agitated for up to 3 days (and nights) prior to the next scheduled meeting with my advocate during this harrowing period.

It is recommended that consideration be given to introducing some form of standardised approach to recruitment, training and ongoing evaluation to assist in delivering a consistent level of service through these outsourced arrangements. Consideration should be given to providing these officers with a minimum level of training in counselling skills.

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