Chapter 21

Post-deployment welfare

21.1 The committee has noted the potential for Australian personnel involved in overseas deployments to be exposed to a range of operational, environmental and occupational hazards. In this chapter, the committee considers the post-deployment care of, and support available to, Australian peacekeepers, and related matters including:

- debriefing and reintegration procedures;
- care and services available to those suffering adversely from service as a peacekeeper;
- post-traumatic stress disorder;
- medical records; and
- health studies.

Debriefing and medical clearance

21.2 The following section considers the steps taken to ensure that the reintegration of Australian peacekeepers back into Australian working and family life is as smooth as possible and that those requiring special post-deployment support or care receive it.

ADF

21.3 Defence informed the committee that personnel have both a Return to Australia (RTA) medical screen and Return to Australia psychological screen (RtAPs). They are usually conducted in the area of operations in the week prior to returning to Australia. For personnel returning urgently, or for smaller operations, the screening is done in Australia as soon as possible after return. These checks are compulsory.

21.4 RTA medical screening involves a standardised health questionnaire and physical examination, documentation of hospital admissions and of exposure to hazards during deployment. Health countermeasure medications (such as malaria eradication treatment) are also prescribed as appropriate for the operation. The RtAPs covers a series of standard psychological screening instruments:

- Deployment Experience Questionnaire, Kessler 10 Questionnaire;
- Traumatic Stress Exposure Scale—Revised;
- Post-Traumatic Stress Disorder Check list—Civilian;
- Major Stressors Inventory, and Alcohol Use Disorder Identification Test for those deployments where alcohol consumption is permitted; and

- a structured interview by a psychologist or a psychological examiner.[1]

21.5 According to Defence, these health screens are followed up with a post-deployment medical check and a post-operational psychological screen. The post-deployment medical check covers an annual health assessment, post-deployment screening for HIV and Hepatitis C and, if indicated, tuberculosis. The post-deployment medical check and psychological screen are usually conducted three months after return to Australia. These checks are also compulsory.[2]

Reservists

21.6 The Regular Defence Force Welfare Association (RDFWA) stated that reservists deployed on operations are often discharged immediately after their return and are then no longer covered by ADF medical services. It stated:

> This group may not seek medical advice for a condition that to them may appear benign but may be related to service in a particular area. Our recommendation is that any member returning from a peacekeeping operation in which environmental health problems have been identified should have access to comprehensive medical care for a period of six months. We understand that the US Veterans Administration has such a scheme for their reservists. A similar scheme could be administered by either the ADF or DVA.[3]

21.7 In light of the often delayed onset of signs and symptoms from conditions such as PTSD or health complications due to exposure to environmental hazards including certain chemicals, the committee notes the importance of continuing access to ADF medical services. It agrees with the RDFWA that reservists should not be disadvantaged because they may leave the ADF soon after returning from deployment. It draws the concerns expressed by the RDFWA to the attention of the ADF.

AFP

21.8 The AFP's Reintegration Coordination Team (RCT) is responsible for supporting deployed officers throughout their deployment, from the moment an officer applies to serve offshore. It considers the destination and duration of deployment and its impacts on the officer's career. The RCT has 'a full-time career development officer who will help people offshore to continue their own development'. This approach is taken because the AFP wants 'people to realise that serving offshore may actually enhance, rather than be a detriment, to his or her career'

---

1 Defence, answer to question on notice W18, 24 July 2007.

2 Defence, answer to question on notice W18, 24 July 2007.

3 *Submission 8*, p. 3.

Indeed, Assistant Commissioner Jevtovic said in an interview that the RCT is 'an integral part of the way we support our people into the future'.[4]

21.9 RCT provides a post-deployment program for officers who have been on an overseas deployment for 40 weeks or longer. The program consists of six components:

- member recognition function (voluntary);
- operational/mission debrief and member feedback process (mandatory);
- career planning and development service (voluntary);
- member re-induction course—organisational information (e.g. legislation and policy changes) (mandatory);
- psychological clearance and welfare briefing (mandatory); and
- medical clearance and briefing (mandatory).

21.10 Members deployed between 16 and 40 weeks and state and territory police in IDG missions participate in the same program except for the career coaching and re-induction which 'are not seen as necessary reintegration components' for this group.[5]

Committee view

21.11 The committee notes the package of post-deployment re-integration and health screening programs conducted by the ADF and the AFP. These programs indicate that both the ADF and the AFP are aware of the importance of the post-deployment care of their personnel. Evidence before the committee suggested that in general, the level of care and attention provided to Australian personnel was appropriate. There were, however, a number of significant matters that warrant closer examination. They relate to post-traumatic stress disorder, medical record keeping, the availability of statistics on the health and welfare of veterans and health studies of veterans. The concerns were raised in relation to the ADF.

Post-Traumatic Stress Disorder

ADF

21.12 A number of submitters referred to the incidence of Post-Traumatic Stress Disorder (PTSD) in ADF personnel who have served in some very difficult peacekeeping operations.[6]

21.13 When asked about the number of claims due to PTSD, the Department of Veterans' Affairs (DVA) was not able to provide concrete statistics. Instead, Mr Mark

---

4 Assistant Commissioner Paul Jevtovic quoted in Juani O'Reilly, 'Policing the neighbourhood and keeping peace in the Pacific', *Platypus Magazine*, Edition 96, September 2007, p. 14.

5 Australian Federal Police, answer to written question on notice 11, 25 July 2007.

6 See for example, APPVA, *Submission 16*, paragraphs 3.5–3.6, p. 2.

Johnson, National Manager, Compensation Policy, referred to the number of people who had had a mental condition accepted under the *Safety Rehabilitation and Compensation Act* (SRCA).[7] For example, 183 claims had been accepted for mental disorders relating to service in East Timor.[8] In answer to a question on notice taken during a 2007 estimates hearing, DVA provided the following statistics on the claims for disability pensions relating to mental health issues that it had received as at June 2007.[9]

Veterans' Entitlements Act (VEA)	Iraq	Afghanistan	East Timor	Solomon Islands
Number of mental health disabilities claims	105	163	1,469	128
Number of mental health disabilities claims accepted	71	120	1,101	89

21.14 It should be noted that medical experts in mental health tend to agree that mental health problems associated with PTSD may become apparent sometime after the initial trauma.[10]

21.15 In contrast to the lack of accurate statistics on PTSD in ADF personnel, the AFP produced clear figures for the committee.

AFP

21.16 The AFP informed the committee that 16 claims had been lodged with COMCARE that relate to PTSD. Of these, 13 claims were accepted and 3 claims were rejected. The table below shows number of claims and costs associated with East Timor and Solomon Islands.[11]

7 *Committee Hansard*, 24 July 2007, p. 34.

8 *Committee Hansard*, 24 July 2007, p. 30.

9 DVA, answer to question on notice 33 (iii), Budget Estimates 2007–2008, 31 May 2007, pp. 12–13.

10 See comments by Wing Commander Alexander C McFarlane, 'Military mental health in the 21st century', *ADF Health*, vol. 4, April 2003, pp. 1–2; Alexander C McFarlane and Mark Creamer, 'Current knowledge about psychological trauma: a response to Milton', *ADF Health*, vol 7, October 2006.

11 AFP, answer to written question on notice 22, 25 July 2007.

Cost Centre Name	Claims lodged	Claims Accepted	Claims Rejected	Costs to Date	Likely Future Cost	Estimated Cost*
East Timor	12	9	3	$1,355,936.36	$1,244,995.00	$2,600,931.3
Solomon Islands	4	4	0	$269,820.10	$335,147.00	$604,967.10

*Includes 'Costs to Date' and 'Likely Future Cost'

Committee view

21.17 The committee finds the inability of the ADF or DVA to provide the committee with full and complete details on the incidence of PTSD in ADF peacekeepers highly unsatisfactory. The committee continues its consideration of statistics later in the chapter but first considers the approach taken with regard to promoting the mental health of ADF peacekeepers.

ADF preventative measures

21.18 The committee previously touched on mental health in the context of prevention through the mission's mandate which, the committee argued, should match the 'conditions on the ground' and not unnecessarily jeopardise the wellbeing of Australian peacekeepers. It especially noted instances where an inadequate mandate placed peacekeepers in a situation where they were unable to intervene to protect innocent civilians from attack.

21.19 It is clear that while a peacekeeping operation may expose peacekeepers to circumstances that pose a risk to their mental health, there are measures that can be taken to reduce risk, especially during pre-deployment training.

21.20 The committee notes that a number of studies have observed that the mental preparation for a combat mission differs from that of a peacekeeping operation. Such studies identify the requirement to exercise restraint in the face of provocation as a major stressor for peacekeepers.[12] For example, writing in *ADF Health* in 2003, Major Karl Haas noted that peacekeeping missions that 'bring soldiers into warzones as non-combatants present 'a wide variety of stresses that have short- and long-term effects on mental health':

12 Rouja Nikolova et al, 'Psychophysiological Assessment of Stress and Screening of Health Risk in Peacekeeping Operations', *Military Medicine,* vol. 172, issue 1, Bethesda, January 2007; and Marie-France Guimond et al, 'Health concerns of peacekeeping: a survey of the current situation', McGill University, 2001, p. 8, http://www.jha.ac/articles/a067.htm (accessed 13 June 2007). They recognise that: 'the peacekeepers' role as a buffer between warring parties while restricting the demonstration of any forms of aggression can indeed have a very severe impact on peacekeepers'.

> Soldiers are trained to win the day by the application of tactics and up to date weaponry, yet peacekeeping and humanitarian missions generally restrict tactical freedom and the use of force, exposing soldiers to stresses for which they are not prepared or trained.[13]

21.21 Professor Mark Creamer, Australian Centre for Post-Traumatic Mental Health, stated in October 2006 that peacekeeping 'generally requires a whole different and complex set of skills, often…for which people are not necessarily terribly well trained'.[14] Indeed, the UN recognises that 'stress management training has become an increasingly important factor in the adequate preparation and training of United Nations peace-keepers'.[15] Earlier in this report, the committee supported the comments by Lt Gen Gillespie that training for peacekeeping operations is to take a 'more prominent place' in ADF training. In so doing, the committee advises that mental health training and support must be given priority.

21.22 The importance of elevating mental health education and training in ADF pre-deployment preparation is evident when considering mental health literacy. During an estimates hearing, Dr Graeme Killer, Principal Medical Officer, DVA, highlighted concerns about health education. He stated:

> …when we looked at the younger peacekeepers and peacemakers in this study, which was called Pathways to Care, we found that they had very low levels of health literacy. They did not really understand what the trauma had done to them in the way they were feeling and they were dealing with their families. So many of them, because the consultation and medication had not worked, would often then self-medicate with alcohol.[16]

21.23 In response to this statement, Defence informed the committee that mental health literacy was recognised in the *ADF Mental Health Strategy* that was launched in 2002. Defence also asserted that all problems relating to mental health are 'thoroughly assessed and managed'. In addition, it noted that eighteen fact sheets had been developed on various topics, including depression, alcohol, drug use and PTSD. Defence said:

> A major focus of the strategy is aimed at breaking down barriers to care, including the concept that mental ill health is a sign of weakness. Defence

---

13 Major Karl L Haas, 'Stress and mental health support to Australian Defence Health service personnel on deployment: a pilot study', *ADF Health*, vol 4(1), 2003, p. 19. See also, Wing Commander Alexander C McFarlane, 'Military mental health in the 21st century', *ADF Health*, vol. 4, no. 1, April 2003. He wrote, 'Unlike combat, where the soldier is well trained to act, peacekeeping requires soldiers to demonstrate restraint by example. Training for these roles as a conflict modulator and provider of humanitarian aid is more ambiguous and difficult'.

14 ABC Radio National, 'Background Briefing', Interview, 29 October 2006.

15 UN Department of Peacekeeping Operations, *UN Stress Management Booklet,* 1995.

16 *Estimates Hansard*, 31 May 2007, p. 137.

> members are encouraged to maintain a sense of personal well-being and to develop a healthy and physically fit lifestyle.[17]

21.24 Even so, Mr Paul Copeland, National President of APPVA, was more circumspect about the adequacy of the strategy. He observed that from the association's experience, mental health was 'significant in policy; marginal in reality'.[18]

21.25 This view emphasises the importance of the ADF ensuring that its policy on mental health translates into changes in organisational culture, attitude and practice which should start in the training establishments. All personnel about to be deployed to a peacekeeping operation should, as part of their preparation, participate in a comprehensive education program on PTSD and other mental health issues. The effectiveness of this program should be subject to continuing evaluation and review.

21.26 The committee now looks at the assistance and support network provided for ADF personnel with regard to mental health.

Services available for PTSD in the ADF

21.27 Training alone will not prevent the occurrence of mental health problems. The committee accepts that the risks to mental health cannot be entirely eliminated and that some Australian peacekeepers in the course of their duties in an overseas mission will experience circumstances that may cause psychological harm. Mr Copeland stated:

> You can go through all the preparation in the world but, when you go over there and come up against these situations, different people act differently. Unfortunately, there has been a large number of cases of post-traumatic stress disorder, depression, anxiety and generalised anxiety disorder: probably 25 per cent of the force that went to Rwanda; a large number that went to Somalia in the first push with the battalion group and the UNOSOM Australian contingent thereafter; and also a large number who went to Cambodia. It is interesting to note the large number of people reporting from East Timor as well. We know that you can be trained up as much as you can but, when it comes to these situations, nothing will prepare you. It is about your reaction and your resilience. You will find that the adrenaline will kick in for soldiers and their training will come into being. Once that has finished and the adrenaline has calmed down, then you will find the effect of that actual incident may be severe. Therefore, peer support or counselling may be needed or critical incident stress management would be needed as well.[19]

---

17 Defence, answer to written question on notice W25, 24 July 2007.

18 *Committee Hansard*, 21 August 2007, p. 51.

19 *Committee Hansard*, 21 August 2007, p. 50.

21.28 According to the ADF, it has a comprehensive program to assist with the diagnosis and treatment of mental health problems, including PTSD. The then Minister for Veterans' Affairs informed Parliament in March 2006 that the ADF had 'one of the largest workplace mental health support systems in Australia that provides a wide range of mental health and counselling services'. He explained:

> The ADF provides mental health support across the deployment cycle inclusive of pre-deployment screening and psychological briefings, the provision of embedded (Australian or coalition) and/or 'fly-in' mental health support and the conduct of post operational psychological screening and programs to assist re-integration after returning from the operational environment. Additionally, veterans of deployments are also able to access the services of the Vietnam Veterans' Counselling Service.[20]

21.29 The services include:

- a wide range of mental health services through public and private hospitals, psychiatrists, psychologists, general practitioners; and
- the development of strong working relationships with experts in the field of mental health notably the Australian Centre for Posttraumatic Mental Health.

21.30 With the support of DVA and relevant government ministers, this centre has for many years been conducting research, providing policy and service development advice on the mental heath issues in veteran and military populations.[21]

21.31 The ADF has also:

- produced the policy document 'Towards Better Mental Health for the Veteran Community';
- undertaken the Pathways to Care study; and
- established the National Veterans Mental Health and Wellbeing Forum.[22]

21.32 Despite assurances provided by the ADF and DVA about the adequacy of the services they provide in the area of mental health, evidence suggests that there are shortcomings.

21.33 In its pre-election policy document, the current government made a commitment to 'ensuring the very best mental health support' would be available for ADF personnel and the ex-service community. It announced that it would 'implement an ADF Mental Health Lifecycle Package of mental health research and innovative interventions, in partnership with the Australian Centre for Posttraumatic Mental

---

20 Senator Ian Campbell, answer to question on notice 1164, *Senate Hansard*, 29 March 2006, pp. 193–194.

21 Australian Centre for Posttraumatic Mental Health, *Annual Report 2006–2007,* pp. 4 and 7.

22 Senator Ian Campbell, answer to question on notice 1164, *Senate Hansard*, 29 March 2006, pp. 192–193.

Health'.[23] As noted earlier, this centre has been working on the mental health of veterans and military personnel for some time. This commitment is now reflected in the government's May 2008 Budget. It has allocated $3.8 million over four years to introduce a package of nine strategic mental health initiatives to improve access to mental health services for current and former ADF members and active reserve personnel. According to the budget statement:

> This initiative will be integrated across the four stages of an Australian Defence Force member's career lifecycle: recruitment, service, transition or discharge, and rehabilitation and resettlement into civilian life. The package aims to enhance psychological resilience among serving members, ensure successful transition into civilian life and provide effective rehabilitation and support.[24]

21.34 The committee supports the government's initiative but notes that PTSD and other mental health conditions have been a source of concern for many decades.

Care for personnel with PTSD or related illness

21.35 Concerns with the detection, diagnosis and treatment of mental health problems in ADF personnel are not new and have been the subject of much parliamentary and media discussion.[25] Mr Paul Copeland referred to the ADF Mental Health Strategy launched in 2004 and explained that the rehabilitation program provides 'the soldier with the maximum time and ability to rehabilitate'. He then noted:

> Unfortunately, we are still having people reporting that, once they have been diagnosed with post-traumatic stress disorder, for example, they are being given a notice of termination and they are out the door medically. It is a heartbreaking moment; I can say that from my own personal situation. You feel that you have done 120 per cent for the Australian Defence Force and the country and, when you come back you become ill and all the ADF seem to be doing to you is wanting to get rid of you. So it is quite a significant impact on that veteran and his family.[26]

21.36 Two members from ATST-EM were also critical of the post-deployment care provided for mental health problems. Captain Wayne McInnes stated:

---

23 Australian Labor Party, *Labor's Plan for Defence,* Election 2007, Policy Document, November 2007, pp. 13–14.

24 Budget Paper No. 2, Budget Measures 2008–9, p. 294. The Government is also providing '$1.5 million over four years to provide training and workshops for community mental health workers who treat veterans. This proposal will help improve practitioners' ability to identify and treat service-related mental health problems. This will result in earlier and more effective treatment of such problems'.

25 See for example, ABC Radio National, 'Background Briefing', 29 October 2006; Standing Committee on Foreign Affairs, Defence and Trade, *Estimates Hansard*, 14 February 2007, pp. 146–148.

26 *Committee Hansard*, 21 August 2007, pp. 50–51.

> Lip service was paid to the needs of ATSTEM personnel rotating out of country many failed to be correctly screened for Psych procedures and still carry the scars of their deployment today.[27]

21.37 While submission 7 stated:

> Three months after I returned to Australia I was post deployment debriefed, I expressed concerns about some difficulties I was having adjusting and was told it will settle down you will be fine if you have any further issues call this number, four years later I am still waiting for it to 'settle down'.[28]

21.38 Mr Mark Johnson, DVA, explained that people can get treatment for PTSD even if DVA has not accepted the condition as related to service. He stated:

> That is treatment that we will pay for. There is a range of treatments available, from both hospital-type care to non-residential-type care. So people can come to the department and ask us to pay for treatment as long as they have a diagnosed condition…If they consider it is due to their service and we accept the condition then we will pay for all care. It is the same with any condition. If the Commonwealth has accepted liability for the condition due to service then all treatment is paid for…There is no time cut-off. In fact, under SRCA most of our claims are some years after the date of injury.[29]

21.39 The committee notes the importance of ensuring that all ADF peacekeepers are appropriately screened for mental health concerns and receive the appropriate care when needed. It is firmly of the view, however, that compensation in the form of payment for treatment does not adequately address the problem. The committee believes that the ADF has a duty of care to ensure that mental illness is managed properly. In this regard, it notes Mr Paul Copeland's observation that 'all the ADF seem to be doing…is wanting to get rid of you'.[30] The committee would like to see indications that the ADF is committed to the long-term care and rehabilitation of members even where, because of their mental health, they are no longer serving members.

Stigma of PTSD

21.40 There is no doubt that the ADF has programs in place designed for the early diagnosis and treatment of mental problems but one of the most significant impediments to promoting mental health, particularly in the ADF, is the reluctance to seek help. This hesitancy to report or seek help for a mental health problem is a well-recognised problem. In 2003, Major Karl Haas wrote in *ADF Health*:

---

27 *Submission 5*, p. 3.

28 *Submission 7*, p. 4.

29 *Committee Hansard*, 24 July 2007, p. 34.

30 See paragraph 21.34.

> More of the 2002 group were aware of the availability of counselling services than the 1999 group, but no survey participants actually used counselling services. Most of the 1999 group and half of the 2002 group indicated that they would not use counselling services to cope with stress, even if they were available. This is of concern, as the survey respondents were health personnel who should have had an understanding of the value of mental health interventions.[31]

21.41 He concluded:

> The reluctance to use mental health services may be attributable to a perception that using such services is an admission of inability to cope and meet the obligations of a soldier.[32]

21.42 More recently, Professor Alexander McFarlane and Professor Mark Creamer observed in *ADF Health* that one of the most critical problems with mental health is 'the failure to diagnose these conditions early and ensure early treatment'. In their opinion:

> The natural hardiness of individuals and a willingness to deny suffering means that many struggle with their symptoms over a long period. This leads to secondary disabilities and adverse social consequences. Marital relationships are likely to suffer, as is work performance.[33]

21.43 They highlighted 'the importance of ongoing research into human adaptations to traumatic stress'.[34]

21.44 The committee received similar evidence during this inquiry. For example, Mr Paul Copeland was of the view that:

> The stigmatisation issue is still there within the Defence Force. I think, until that stigmatisation evaporates within commanders and local commanders on the ground, at the coalface, you will find people who will be reluctant to report such illnesses, and they will try to hold the chain as long as they can until they are at breaking point. There is a debriefing system in place. RTAPS is one; there is Return to Australia Psychological Screening in country and the psychological screening when they are at home some three months afterwards. Some people have slipped through the gaps. I am not

---

31 Haas, K, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 2003, vol 4, no 1, p. 21.

32 Haas, K, 'Stress and mental health support to Australian Defence Health Service personnel on deployment: a pilot study', *ADF Health*, 2003, vol 4, no 1, p. 21.

33 Professor Alexander McFarlane and Professor Mark Creamer, 'Current knowledge about psychological trauma: a response to Milton', *ADF Health,* 2006, vol 7, no 2, p. 81. See also, Wing Commander Alexander C McFarlane, 'Military mental health in the 21st century, *ADF Health*, vol 4, no 1, 2003, p. 1.

34 Professor Alexander McFarlane and Professor Mark Creamer, 'Current knowledge about psychological trauma: a response to Milton, *ADF Health,* 2006, vol 7, no 2, p. 79.

> saying that it is a perfect model, but there are some gaps in there that people are slipping through.[35]

21.45 In its 2005 report on Australia's military justice system, the committee recognised that one of the major health challenges facing the ADF was to counter the attitude that seeking help is an admission of weakness.[36] It urged the ADF to acknowledge that the military culture makes it difficult for members to ask for help, and to put in place services that take account of, and compensate for, this failing. Today, the committee again notes that one of the most difficult challenges for the ADF is to remove many of the existing prejudices associated with psychological disorders.

Committee view

21.46 The committee understands that service in a peacekeeping operation brings with it psychological challenges. It recognises the measures implemented by the ADF regarding the prevention, detection and remediation of mental illness. The committee notes, however, that the stigma attached to mental health remains a critical barrier both to reporting mental health problems and to receiving treatment for mental health conditions.

Statistics

21.47 There is no doubt that the mental health of Australian peacekeepers remains an area that needs close attention. Australia is not the only country grappling with how to prevent and manage the problem. A clear and precise understanding of the extent and nature of mental health concerns among returning peacekeepers is required to both design an effective preventative education program and to make available the most appropriate services for those who need care. The data available on the incidence of PTSD in Australian peacekeepers, however, does not present a clear picture. The committee now looks more generally at the statistics available on the health concerns of ADF peacekeepers.

21.48 One of the primary indicators of the health and safety problems encountered by ADF personnel comes from the claims they have submitted. Australian peacekeepers may claim assistance for medical services or compensation for disability under three main pieces of legislation—*Veterans' Entitlements Act 1986* (VEA), the *Safety, Rehabilitation and Compensation Act 1988* (SRCA) and the *Military Rehabilitation and Compensation Act 2004* (MRCA). This legislation is discussed in greater detail in the following chapter.

21.49 DVA informed the committee that under the VEA approximately 1,600 veterans with eligible peacekeeping service have submitted claims for disabilities.

---

35 *Committee Hansard*, 21 August 2007, p. 51.

36 Senate Foreign Affairs, Defence and Trade References Committee, *The effectiveness of Australia's military justice system,* June 2005, paragraphs 15.6–15.9.

Mr Johnson, DVA, stated that this figure represented those captured on the department's system since the early 1980s, which would 'be pretty much for all our peacekeeping operations'.[37] Under the SRCA, 1,300 claims for service in East Timor have been lodged. Mr Johnson pointed out, however, that some of those would be people who had dual entitlements and may have claimed under both the VEA and the SRCA.

21.50 DVA could not provide a breakdown of the causes for the claims under the VEA but could do so for those under the SRCA. Mr Johnson stated:

> …for East Timor out of approximately 1,300 claims 1,047 have been accepted and, of those, 440 are for what is classified as injury and poisoning, 183 for mental disorders, 122 for infectious and parasitic diseases—these are accepted—100 for diseases of the musculoskeletal system and then the others come into other categories.[38]

21.51 For RAMSI, DVA had received 45 claims, and 94 claims for Bougainville. Mr Johnson explained that he did not have figures for others because they had been difficult to retrieve from the system.[39]

21.52 Information provided to the committee in response to a question on notice taken during Estimates in May 2007 produced a different set of statistics.

21.53 As at June 2007, DVA had received the following claims for disability[40]:

Veterans' Entitlements Act (VEA)	Iraq	Afghanistan	East Timor	Solomon Islands
Number of claims received	1,585	2,345	13,846	1,119

21.54 It should be noted that the number of claims approximately equals the number of conditions, but not number of persons.[41] Thus, these figures may well align with those provided by Mr Johnson to the committee.

---

37 *Committee Hansard*, 24 July 2007, p. 29.

38 *Committee Hansard*, 24 July 2007, p. 30.

39 *Committee Hansard*, 24 July 2007, p. 29.

40 Department of Veterans' Affairs, Answer to question on notice 33, Budget Estimates 2007–2008, May 2007.

41 The most commonly claimed conditions under the VEA include: tinnitus, osteoarthrosis, acute sprain or strain, sensorineural hearing loss, lumbar spondylosis, chondromalacia patella, intervertebral disc prolapse, fracture, Post-Traumatic Stress Disorder and internal derangement of the knee.

21.55 The committee is concerned that DVA could not produce comprehensive and detailed statistics on the number of peacekeepers who have made a claim for disability due to peacekeeping service, the nature of the disability and the relevant operation.

21.56 DVA also provided information on compensation claims, other than those for the disability pension, that had been made under the MRCA and SRCA, Income Support and 'treatment only' health care benefits. The number of those claims, determined under the different Acts for the four conflicts to June 2007 were:

VEA	MRCA	SRCA
931	885	1,579

21.57 The most common claims under the VEA were for invalidity, qualifying service, malignant neoplasm, PTSD and depressive disorders. Under the MRCA and SRCA, the most common claims were for injury and poisoning, mental disorders, diseases of the musculoskeletal and nervous systems, and parasitic and other infections.[42]

Committee view

21.58 The committee is concerned about the vagueness of the statistics produced by DVA, particularly its inability to provide precise information on the number of claimants and nature of claims as they relate to specific deployments.

21.59 Despite the absence of full and complete figures, the committee is in no doubt that many of those who deploy to a peacekeeping operation encounter an environment or situations that heighten the risk to their physical or mental health. The committee is interested in the health studies that have been undertaken that would provide an insight into the problems encountered by peacekeepers.

Health studies

21.60 DVA informed the committee that it had not conducted a study of the effects of service in peacekeeping operations on the personnel who have taken part in peacekeeping operations. Mr Johnson stated:

> …Defence are doing various studies with pre- and post-deployment in some of their more recent deployments. We have done lots of health studies, but not one on peacekeeping that I can recall.[43]

---

42 Department of Veterans' Affairs, Answers to questions on notice, Budget Estimates 2007–2008, May 2007. It should be noted that the Department of Veterans' Affairs provided the following statistics to ABC Radio National, 29 October 2006, about claims by veterans of the East Timor peacekeeping operation. Although produced a year earlier than the ones provided above, they indicated that 12,895 claims had been made by 2,782 veterans of which 8,767 claims had been accepted. Of the 2,782 veterans to have made claims, 316 had no claims accepted.

43 *Committee Hansard*, 24 July 2007, p. 29.

21.61 He explained that one of the major challenges in conducting health studies is establishing a roll of ADF persons who participated in a particular operation and establishing a comparison group. He stated:

> If you are going to do a health study, you need to have a reasonable number in the health study to get scientific power in the study to reach some reasonable conclusions from any results that come out of the study. Some deployments that are very small are difficult because of that. Different deployments may have different factors—for example, environmental factors…I would have thought that lumping them together would also be difficult. You would have such a jumbled group and to come to any conclusions about the health impacts, or otherwise, of the aggregate group would be very difficult.[44]

> In the past when the department has done studies, one of the first things that it has tried to do has been to establish some sort of nominal roll of people that participated in, for instance, the conflict in Vietnam or in the British nuclear tests. That is very time consuming. It is difficult to get current names and addresses and to seek the permission of those people to participate.[45]

21.62 Defence agreed that issues concerning the health of veterans of past deployments have been difficult to resolve because insufficient data was collected at the time of those deployments. The absence today of reliable data on the health of peacekeeping veterans, as noted earlier by the committee, highlights the pressing need for the ADF to have a comprehensive database on ADF members, their service and related health problems.

21.63 It should be noted, however, in 1999 the then Minister for Veterans' Affairs announced a new health strategy for overseas deployments that *inter alia* would include the compilation of the nominal rolls for all significant overseas deployments over the past decade and health reviews for all future overseas deployment.[46] As foreshadowed in this announcement, Defence, assisted by DVA, have established a program of post-deployment health surveillance. This program, the Deployment Health Surveillance Program (DHSP), is conducting retrospective studies on East Timor, Bougainville and Solomon Islands veterans. The Centre for Military and Veterans' Health, established in April 2004, is undertaking this longitudinal health surveillance on ADF deployed personnel, including peacekeepers. The health effects of specific deployments currently being investigated include Solomon Islands, Bougainville and East Timor.[47]

---

44 *Committee Hansard*, 24 July 2007, p. 31.

45 *Committee Hansard*, 24 July 2007, p. 30.

46 The Hon Bruce Scott MP, Minister for Veterans' Affairs, Minister Assisting the Minister for Defence, Media release, Min 191/99, 5 July 1999.

47 DVA, answer to question on notice 2, 24 July 2007.

21.64 The program is a joint venture involving Defence, DVA and a consortium consisting of the University of Queensland, University of Adelaide and Charles Darwin University. According to Defence, the studies are similar to those being conducted by allies such as the US and the UK. It anticipates that the studies 'will inform a continuing, comprehensive health surveillance program for the ADF, concentrating on the health effects of operational deployments'.[48] The short-term benefits identified during a presentation on the program include:

- improved documentation and measurement of occupational and environmental exposure;
- contribution to improving Defence health record systems;
- early identification of deployment health issues; and
- systematic review of literature about specific deployments.

21.65 The anticipated longer term benefits are:

- better quality information to guide interventions to prevent chronic disability; and
- scientific evidence on health effects of deployment.[49]

21.66 In addition, through its applied research program, DVA is funding smaller studies of other peacekeeper deployments.[50]

21.67 In March 2008, the Minister for Defence Science and Personnel called on current or former ADF personnel to take part in the Timor-Leste and Bougainville Health Study by the Centre for Military and Veterans' Health. In May 2008, he announced a review of mental health care in the ADF and the transition to non-military life. This review will examine existing mental health programs and support across the ADF and DVA and 'advise on their effectiveness, gaps in services, and challenges in delivery. It will also examine and advise on the transition process between the ADF and DVA'.[51]

Committee view

21.68 The committee is unaware of any reliable data that has been collected or analysed on the clinical profiles of Australian peacekeepers. The lack of clear detail regarding the health and welfare of peacekeeping veterans leaves a significant void in Australia's understanding of the effects that a peacekeeping operation may have on

---

48 Defence, answer to written question on notice W26, 24 July 2007.

49 Deployment Health Surveillance Program (DHSP) Stakeholder Day, Presentation at the DHSP Stakeholder Meeting in Canberra, 29 March 2007.

50 DVA, answer to question on notice 2, 24 July 2007.

51 The Hon Warren Snowdon MP, Minister for Defence Science and Personnel and the Hon Alan Griffin MP, Minister for Veterans' Affairs, 'Review of Mental Health Care in the ADF and Beyond', Media release, 060/2008, 26 May 2008.

those who serve in such operations. This gap means that those responsible for preparing peacekeepers for service are at a disadvantage in devising programs and training that might address and help prevent potential health and safety issues. The committee sees a definite need for more effective means of gathering, collating and analysing information on all aspects of the health and welfare of those who have participated in a peacekeeping operation.

21.69 The committee also recognises the need to improve public discussion and understanding of the health aspects of peacekeeping. Health studies should be an integral and continuing part of a preventive policy to minimise dangerous exposure to disease, unsafe work practices or environments. Although only in its early phase, the ADF Deployed Health Surveillance Program appears to address many of the committee's concerns about the absence of data. Even so, to underline the importance of conducting comprehensive studies and continuing surveillance of the health problems and needs of those who serve in peacekeeping operations, the committee asserts that a more effective military medical surveillance system is required. It makes the following recommendations.

Recommendation 26

21.70 The committee recommends that the ADF develop a comprehensive and reliable database on Australian peacekeepers that would provide accurate statistics on where and when ADF members were deployed. The database would also enable correlations to be made between particular deployments and associated health problems.

21.71 The committee notes the importance of ensuring that all ADF peacekeepers are appropriately screened for mental health concerns and receive the appropriate care when needed. It is firmly of the view, however, that compensation in the form of payment for treatment does not adequately address the problem. The committee believes that the ADF has a duty of care to ensure that mental illness is managed properly. In this regard, it notes a witness's observation that 'all the ADF seem to be doing…is wanting to get rid of you'.[52] The committee would like to see indications that the ADF is committed to the long-term care and rehabilitation of members, even where, because of their mental health, they are no longer serving members.

Recommendation 27

21.72 The committee recommends that the ADF broaden the scope of the research and studies being done on veterans' mental health by the Australian Centre for Posttraumatic Mental Health and the Centre for Military and Veterans' Health to include the rehabilitation of veterans with mental health problems; the retraining opportunities or career transition services provided to them; the quality of, and access to, appropriate and continuing care; and the stigma attached to mental health problems in the ADF.

---

52 See paragraph 21.34.

21.73 The committee notes that while some government and university sector research has been undertaken into the health of Australian peacekeepers, as yet, it has not been brought together to inform Australian peacekeeping practice. The national peacekeeping institute, outlined in Chapter 25, would provide a mechanism for drawing together the existing research capacity, whilst also providing a critical link between government and non-government sectors.