

4. Key Informant and In-Depth Interviews

Review into the Suicide and Self-Harm Prevention services available to current and former serving ADF members and their families

National Mental Health Commission

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Abbreviations

| Abbreviation | Definition |
|--------------|--|
| ADF | Australian Defence Force |
| ADSO | Alliance of Defence Service Organisations |
| ASIST | Applied Suicide Intervention Skills Training (Program) |
| CO | Commanding Officer |
| DART | Defence Abuse Response Taskforce |
| DCO | Defence Community Organisation |
| DFA | Defence Families of Australia |
| DVA | Department of Veterans Affairs |
| ESO | Ex-Service Organisations |
| GP | General Practitioner |
| IT | Information Technology |
| JHC | Joint Health Command |
| MEAO | Middle East Area of Operation |
| NGO | Non-Governmental Organisation |
| PTSD | post-traumatic stress disorder |
| RSL | Returned Services League |
| VVCS | Veterans and Veterans Families Counselling Service |

Executive Summary

The key informant and in-depth interviews were conducted in the last three months of 2016, and 63 individuals contributed to the Review. The interviews focussed on six specific areas germane to the Review and a wide-ranging response was received.

The incidence of suicide and self-harm

The relevance of comparisons to the general population was challenged, and strong discussions described the ADF as a unique community as a consequence of recruitment, training, culture, hierarchies, deployment, working environments and transitions. These experiences are not shared with the general population and comparisons were generally regarded as vacuous.

Nevertheless, the incidence (rates) of suicide within the ADF was lower than the general population; and the rates for the former-serving population slightly higher. These statistics vary over time (and age-groups) but these trends were consistent.

Key informants were also consistent in their view that the data collection processes for former-serving personnel are haphazard, lack detail, and are difficult to interrogate.

The range of services available to serving and former serving members of the ADF

The range of services available to prevent suicide and self-harm within the ADF was regarded as improving, comprehensive and professional, however there were widely held reservations regarding the outsourcing of services, which, it is argued, has had a negative impact on the range of services and quality of experience within the ADF.

The VVCS was singled out for commendation, notwithstanding that it operates within the constraints of legislation.

The capacity of services within the ADF were often 'location dependent', and the use of services for serving personnel was limited by three key factors:

1. The stigma associated with help-seeking, especially in regard to mental health issues.
2. The negative impact on a person's career path if any 'weaknesses' was declared.
3. The potential limits on deployability in particular if serving personnel seek help.

Significant concern was registered about the quality of transition services (i.e. transition from the ADF) and the need for a smoother, family aware, extended transition support service.

The key informants registered concern for the lack of data relating to former serving personnel that is transferred from the ADF to the DVA, the bureaucratic (antiquated) DVA system, the adversarial nature of the compensation claims assessment process, and the limits imposed by legislation constraining opportunities to provide more holistic support.

Ex-service organisations were broadly discussed and, while they are recognised as a significant component of the post-service landscape, the lack of oversight or an overarching framework to coordinate their offerings and standards of care, are seen as concerns.

The effectiveness of services available to serving and former serving members of the AD

The key informants believe the effectiveness of services is limited by a lack of knowledge and understanding of the services and their access pathways.

Outsourcing of services has extended capacity but also increased the complexity of service pathways. The lack of consistency in service delivery, and lack of ADF knowledge and experience (i.e. 'veteran literacy') among GPs and other service providers compromises the effectiveness of the services on offer.

Stigma surrounding mental health, and the perceived negative impact on career paths and deployability were regarded as pivotal factors discouraging presentation to services, thereby limiting their effectiveness.

Concerns were also expressed for the increasing separation of the Commanding Officer from personnel under medical supervision.

Transition services and programs were regarded with disdain, and identified as a key area for reform.

The effectiveness of the DVA to support former-serving personnel was limited by the nature of the relationship and the services required.

The 'no-liability' 'White Card' was regarded as a 'step in the right direction' however discussion in regard to 'Gold Card' eligibility remains contentious and worthy of review.

Duplication and gaps in current services

A key factor contributing to the duplication of services is the proliferation of Ex-Service Organisations (ESO) and their foray into the provision of support to members.

Specific gaps were identified in the extension of services to families (and former family members), and transition services and programs were singled out for criticism, and were regarded to have failed on every level.

Gaps in screening sensitivity and processes in recruitment were also identified as an area of concern and a potential area of proactive improvement to outcomes.

Barriers to access and utilisation

The barriers to accessing and using services were often discussed in relation to 'effectiveness', particularly in regard to stigma, career pathways, and deployability. Other specific barriers identified include the complexity and (sometimes) adversarial nature of the DVA claims process, which was regarded as a significant barrier that takes its own toll on the mental health of former-serving personnel.

Proactive opportunities provided through resilience training, clarity of transition pathways, and review of 'Gold Card' eligibility were seen as potential responses to overcome these barriers.

The use of services provided outside government

The use of services provided outside government was seen as a consequence of the lack of knowledge and understanding of support pathways, the complexity of government processes, the lack of trust in the government system, and the strength (or otherwise) of the remaining or residual relationship with the ADF post discharge.

Some private (pay for service) health providers, and the ESOs were identified as the services most likely to be used outside the system. The benefit of using such non-government services is a vexed and complex area, and remains a significant challenge for achieving positive outcomes for serving and former serving personnel.

Introduction

Review of Suicide and Self-Harm Prevention Services for Australian Veterans and Defence Force members

The Prime Minister announced an Inquiry into suicide and self-harm prevention services for Australian veterans and serving defence force members in August 2016. The National Mental Health Commission (the Commission) was tasked to lead the Review, and examine the self-harm and suicide prevention services available to current and former members of the Australian Defence Force (ADF), to assess their accessibility and effectiveness.

The Commission is required to present a final report to ministers in late-February 2017.

The Review examines:

- The range of services available to current and former serving members and their families.
- The effectiveness of these services in supporting members and their families while they serve, as they transition from Defence to civilian life, and later in their civilian life.
- Any duplication or gaps in current services and how they might be addressed.
- Any barriers to current and former serving members accessing services, taking into account cultural relevance, availability of providers, employment, functional capacity and degree of ill health.
- The extent to which former serving members utilise services provided by other parts of government, ex-service organisations, the private sector or non-government organisations. (For the Key Informants based internationally, views of the national experience and context were examined).
- The incidence of suicide among serving and former serving ADF members compared to the broader Australian community.

The Review does not examine specific incidents or issues. The focus is on understanding how the system works and identifying opportunities to improve the system, for the benefit of serving personnel and former-serving members, their families and the ADF.

A number of investigations and research tasks were conducted to gather information relevant to the Inquiry's terms of reference. One element of those investigations was to undertake a series of in-depth discussions with a set of nominated key informants (KIs), who are individuals with an informed understanding of how the current system works. The results of these discussions are summarised in this report.

Methodology

This report considers the responses of key informants selected from serving members of the ADF, former-serving personnel, support services and clinicians, academics and researchers.

The KIs (N=51) were provided with an issues guide, consistent with the scope of the review, and the interviews conducted face-to-face or by telephone. Most interviews were approximately 90-120 minutes in length, the notes transcribed and checked for accuracy. In the majority of cases, the interview notes were sent to the interviewee and checked. Only interviews conducted late in the project and some international experts were not afforded this opportunity.

Thematic analysis was then used to identify the underlying issues raised by the key informants: this thematic analysis also allowed for the aggregation of data. Key observations are highlighted in relation to the Review's six terms of reference.

A number of supplementary in-depth interviews were also conducted with individuals (N=12) who either nominated to be involved, or were originally to be involved in a group discussion organised for the Review but

opted to be interviewed instead because they were the only person who registered to attend the discussion. These interviewees include a senior Army commander, a current reservist, a former artillery and commando unit member, two carers, two ex-army members, an ex SAS unit member, a former sailor, a former soldier, and two family members. Seven of the interviewees were male, and five were female.

In qualitative research, data saturation is reached when there is enough information to confidently replicate the findings, and when no further coding is feasible. The semi-structured interview process in this Review allowed for initial coding using the scoping framework, and further coding from informant responses. The informants provided a range of responses and contributions were coded accordingly. The depth of the data in this aspect of the Review reflected the position of saturation – that is, no new data was forthcoming and no new themes emerged.

Incidence of Suicide

The interviewees were invited to consider and describe their knowledge and understanding of the incidence of suicide for serving and former-serving personnel. Comparisons to the general population, and their relevance, were discussed.

The ADF is different from the Australian population

The ADF is 87% male and under the age of 30 years. This presents a selection bias (sometimes referred to as the 'healthy worker' effect) when comparisons are made to the general population.

ADF recruits are believed to be, on average, healthier than the general population. The ADF takes steps (primarily screening) not to recruit individuals with certain pre-existing disorders, and provides rapid response treatment to recruits who present with problems.

While the nature of recruitment and selection will deliver a 'healthier' workforce, many key informants indicated the need to factor in other issues such as the appeal of the ADF for people who are 'risk takers'.

The general public can't really come to grips with the military cohort, and what aspects of their character are unique, which begs the question; what factors are really at work in regard to suicide and suicide prevention? Suicide data is difficult to compare and the ADF suicide rates may be closer to the general population if we compared a 'like' cohort.

Key informants suggested the screening processes for entry into the military should be reviewed to better understand any levels of pre-service trauma (anecdotally present in a proportion of ADF personnel and not captured in screening).

The following key differences between the ADF and the general population were observed:

- the prevalence of exposure to trauma is much higher in ADF than in the general population;
- such traumatic exposure is associated with increased health risks;
- in-service health care is better than the health care available to the general population, but the systems are not operating well in ADF; and
- the ADF culture encourages more dependence and a loss of self-agency.

Rates of suicide

Incidence of suicide

There is good evidence that suicide in current serving ADF personnel is lower than the general population.

There are approximately 56,000 fulltime serving members of the ADF and another 30,000 in reserve (not on active duty). Between 2001-2014, there were 292 certified suicide deaths (272 men and 20 women) among personnel with at least 1 day of ADF service. Of these 84 occurred in the serving full-time population, 66 in the reserve population, and 142 in the ex-service population.

The adjustments for comparison to men in the general population indicate 53% lower for those serving full time, 46% lower in the reserve, but 13% higher for former-serving personnel.

For the former-serving personnel, the data is much less clear and data-matching may not be complete. Many veterans are 'lost in the system' and disheartened after they leave (despite the experience of service being highly regarded).

Impact of service

To say that service personnel have no greater risk than the rest of the population “... is straight out baloney” (KI30).

Between 5,000 – 6,000 personnel leave the ADF each year and most of this is ‘healthy rotational planning’, to move away and lead rewarding lives. But some do not transition well, and management of this needs to be greatly improved.

A key issue was identified within the data; “*What impact does military experience have, as opposed to the general population?*” A soldier’s job is all about ‘death’ and that is reinforced through training and operational expectations. In many way, for the soldier it is:

- part of their obligation to accept the likelihood of death in combat;
- more commonly understood and dealt with from the very start of service;
- a form of de-sensitisation where service might lead to death, and that’s okay; and
- the requirement to inflict death on the enemy is part of the core business of combat.

It was suggested that comparisons with other highly stressful occupations might be of greater relevance as a measure of how well the ADF is addressing this issue.

About 17% of the ADF personnel who are discharged each year leave with a medical discharge. About 25% of all service personnel are vulnerable to mental health problems. Problems develop for those who do not transition to employment. No support, and no employment (after discharge) results in a somewhat “*slippery slope of decline*” (KI9).

It was noted that there is an underlying need for accurate and timely data for two important reasons:

- for an immediate response and to be reflective about the processes that have been historically relevant; and
- so we can look forward from now and begin to plan how to track individuals, how to invest in programs, work for better health outcomes, and build resilience.

There is a data set emerging from the recently conducted Transition and Wellbeing study¹ that will provide current estimates around suicidal ideation, plans and attempts amongst current and recently transitioned (past 5 years) veterans, which will be critical.

Difficulties arise with the need to monitor former service personnel to obtain accurate data, and align appropriate services. Many former-serving personnel do not necessarily want to be identified as former-serving personnel, so one question becomes “*what do you want to do with that kind of surveillance?*” What circumstances would justify closer surveillance of former-serving personnel? It is really up to the individual who needs help to access it. According to the data available, it is a small percentage of veterans (former-serving personnel) who suicide. It is also only a relatively small number of members who need medium to high levels of assistance. Prioritising this over the general and greater numbers of people who need a small amount of help may be counter-productive. The focus on this takes away funds, time and effort from the bigger issue ‘*what actually needs to change?*’

It is clear from the existing data that mental health issues are a significant risk factor for suicide. This begs the question of ‘accountability’ for mental health treatment within the ADF, and reinforces the need for measurable data and an evidence base for early intervention.

¹ Australian Institute of Health and Welfare 2016. Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001-2014. Cat. No 212. Canberra: AIHW

It was suggested that the ADF make available the data for suicide and attempted suicide to allow access to the information therein to researchers to explore and to examine the data for commonalities.

It was observed that the DVA should have the means and capacity to track former-serving personnel and to be able to establish (with confidence) the numbers of deaths to suicide. They have failed the people for whom they are responsible at the moment, but that can be redressed for the future. The DVA is obliged to be abreast of all matters that affect their client; excuses (legislative or otherwise) are unacceptable.

Key informants noted that there are complex factors associated with return from service and the transitions required.

Family issues are often involved as well, and not enough emphasis is given to the pressure on families. Death by suicide of children of former-serving personnel is hidden from view.

The underlying array of risk factors often involve a 'sense of failure' (i.e. career, personal, family). The complexity of operational service might indicate that the risk for suicide is more complicated than the links between trauma and service.

The impact of the military culture was observed to be integral to an understanding of the data, e.g.

- a) The reluctance to admit any medical concerns because of career implications;
- b) The role and nature of stress/support with families of serving personnel;
- c) Particular issues regarding difficult transition to civilian life;
- d) Loss of identity; and
- e) Factors associated with adjustment to civilian life.

Key observations

1. Comparisons between serving (and former-serving) personnel and the general population are misleading. While some features are shared, the ADF culture, training, experiences, and environment distinguishes serving and ex-service personnel as a distinctive group with their own suite of characteristics and challenges.
2. The data sets (collected and available) for serving and former-serving personnel need to be improved to allow timely assessment and accurate research to be conducted.
3. Responses to the data indicators need to include families of serving and former-serving personnel.

Range of Services

The key informants were invited to consider and describe the range of support services available to serving and former-serving personnel who may be contemplating or considering self-harm or suicide.

While there was a clear distinction between the experience for serving members and ex-serving members, there was some commonality in the services available.

Serving personnel

Serving personnel are well placed to access a wide range of services provided through the ADF and Department of Veterans Affairs (DVA) including the Veterans and Veteran's Families Counselling Service (VVCS). Serving personnel have access to internal and external (contract) health professionals provided through ADF Joint Health Command (JHC). In addition, the Defence Community Organisation (DCO) have social workers available to assist families.

Over the last few years these services have improved, with better access and awareness, although some outsourcing of things like garrison health i.e. contracted Medical Officers has made it less effective.

There is still a perception that mandatory training and defence-wide activities are tokenism i.e. simply exists to tick political boxes (KI21)

Serving personnel have a full range of services and can seek assistance through the ADF health centres. This might involve a referral to the psychology unit or professional services, for both in-patient and out-patient care. Most mental health care is provided on an out-patient basis. Individuals can also seek assistance through individual and group programs. Current serving members can self-refer to VVCS and receive a full range of mental health services 'off the book', i.e. the ADF is not necessarily informed about these services, which means these services can be accessed 'anonymously'.

Services within the ADF are substantial (a big investment was made in placing mental health into garrison health) but I believe they are variable in quality and availability. They are contingent upon location, and in high throughput areas ADF garrison treatment for mental health tends to be more triage, which can be problematic as there is little quality assurance in regard to outsourced (contracted) services. (KI29)

In-service the support isn't too bad, but there are still incidences that are unwelcome reminders of the system failure. We have still to come to grips with the stigma attached to mental health problems; we are still limited in our ability to detect early warn signs of problems (because of the culture of teamwork, and the determination to be deployable); and we are still frustrated by peer-to-peer failure when support is required. (KI15)

Nonetheless, there was consensus that matching people to programs was not done well, or in a timely fashion. The services may be there but the use, access, understanding and communication is still limited by a range of factors.

The range and access to services is many and varied, and taxing, but when (you're) not healthy this is even more complex and difficult. (KI9)

The challenge was knowing what is out there, how to access it in a timely way, when to access services, and knowledge of options within the frameworks.

In service there are lots of services available but the knowledge of them (and access) is not so well known. It is important that someone with the (lived) experience can guide you and make

suggestions (recommendations). Padres are ineffective as they are limited to those with whom they may have a connection (and) you can't make it happen; and they are (also) limited because of their rank. (K11)

There were also commonly expressed concerns about mandated training moments and the information provided.

It has to be more than brochures and training seminars, but too often this is the measure of their (ADF) involvement. (K135)

The ADF exist within very tight boundaries, they have strict rules and regulations, they are highly managed and trained...it is hierarchical and predictable. For them, services are available but it is a very structured environment and being available does not necessarily mean accessible. (K112)

While the services within the ADF are comprehensive, some concerns were identified. The provision of services and training appears to be good on paper, but typically gets rolled out in a military way i.e. it is a scheduled program delivered to group on a certain date. There was a shared understanding that there is a lot of information available to service personnel, but it begs the question of its availability when needed. Knowledge does not translate into understanding. A further caveat is the location of the base; some services are not available as a consequence of location (e.g. remote).

For the ADF there are many layers of services listed, but getting access, or timely access is a different question. You can wait months or years to find out about the right service and get access. So knowing what is there and how to get timely access is important. If you are medically downgraded or need rehab then this should be an immediate service triggered rather than something that you have to fight for, search for and discover at the end of your rehab. In short, the policy framework is good, but the functionality is terrible. Often services are only available in name only and that doesn't mean much. The services are listed but that doesn't guarantee there's anyone there that knows how to get them. (K112)

Resilience training provided through 'Battle Smart' provides individuals with coping mechanisms when confronted with traumatic events. The resilience tool/app High Res is also available through the At Ease website and via the DVA website (and App), and helps to normalise/regularise the use of these tools for those personnel accessing this support. Resilience based training was viewed as augmentation to support service (e.g. see also pilot programs at Vasey Resilience Centre in Townsville) and part of a move to a more positive approach to preparing personnel for service in the ADF. It should be noted that the USA Armed Forces have invested heavily in 'resilience training'; however, its efficacy remains largely untested (K130).

Help-seeking has increased and the ADF services are reasonably well placed to respond, but serious concerns were expressed about the use of group work for screening or therapy. In such a closed and scrutinised environment, this is unlikely to be well used or candid. Screening for difficulties in the presence of others can result in massive denial while group therapy, though it has its place and needs to be included, always needs to be supplemented by individual treatment.

Generally, in the ADF the choices are limited, and the challenge is being able to use them effectively. (K135)

ADF commanders and leaders do not have the time or experience in each area of policy to be able to effectively meet their responsibility and accountabilities to members. (K112)

Informants referred to the courses with a suicide prevention focus, such as the ASIST course, but the effectiveness in regard to suicide prevention was not highly regarded. This is consistent with the most recent literature (e.g. Franklin, et. al, 2016), and a cautionary note.

What it has done is to improve listening skills and that might lead to an effective intervention, so in that regard they're useful ... they might be a small part of the solution. (K15)

There was shared concern that personnel seeking treatment were often seen as an administrative liability and burden. Often many people are involved in the treatment planning, and the person seeking treatment can often feel intimidated and reluctant to put all their issues on the table. There is a lack of confidentiality about these matters outside of the realm of clinical medical staff and this contributes to the stigma around injury and illness.

Outsourced psychology and psychiatry services

Numerous concerns were raised about the outsourcing of psychology/psychiatry services. Tertiary services for people with diagnosed mental illness can help ensure mental illness is better managed and symptoms reduced, and this has a protective *impact* on suicide.

It was suggested the ADF relies too heavily on operational, clinical care, and not enough on the important aspects of non-clinical care. Even in a rehabilitation environment, not all the aspects of health and well-being that might be important (including workplace issues and home issues) are explored.

The (referred) patients had seen on average 2-4 psychiatrists. 1 hr interview to get a report. Therapy was predominantly medication-based (and they saw) a psychiatrist for only 10 -15 mins. That is not psychiatry. (K120)

Other concerns were expressed for the provision of sub-acute care, and primary care in the ADF.

I think overall there are limited checks to ensure the best quality evidence-based care is delivered - quality assurance mechanisms are required. (K129)

The system needs better coordination and integration of care at regional levels, tightening links between the three levels of care (primary, secondary and tertiary), improved quality assurance mechanisms and inclusion of assertive outreach capability.

A key informant from overseas provided a stark comparison. The Dutch Department of Defence has four specialist PTSD centres, and then a network of nine other centres that are contracted to provide services. Serving and former-serving personnel can access any of these centres. They are located across the country. There is a specialist workforce – eight psychiatrists, 30 clinical psychologists plus social workers, and mental health nurses.

"It has served us well. We have developed a specialist knowledge and capacity across these centres". (K148)

3.3 Transitions

The main risk is the point of transition. For those on medical discharge, there is more surveillance and monitoring, however many undiagnosed veterans (former-serving personnel) slip through the system and their condition may deteriorate. The transition from serving to ex-serving should be seamless so that the current and ex-serving systems are linked. At the moment you lose support at the very worst time. It should be the point of the strongest connection and at the moment it's a point of disconnection.

A number of key informants indicated a positive change would be to stipulate an 'opt out' clause rather than an 'opt in' clause for transferring files to DVA on leaving defence.

Former-serving personnel

The services offered by the DVA are comprehensive, however perceived difficulties arise in accessing the services, and their timely availability. Concerns were expressed in regard to the disconnect between the available services and the knowledge of access pathways.

In 2004 the Army commissioned Project AKESA (Helping the Hidden Wounded). The intent was to identify how those in need of services at the lowest levels of Army could access the information and systems available at the higher levels. It was disappointing to note that, while programs existed, the information about them rarely trickled down to the soldier and NCO level.

Awareness is the key: you can point to many of the services available but the digger wouldn't know about them, nor would you expect them to because if it's not relevant to their experience they are not interested. Even those with afflictions may not be aware of the services that are available, or how to access them... raising awareness helps, but it is a small component of a bigger problem. (K15)

There was a common concern that access to services offered by the VVCS and the DVA is often driven by need, and may lead to various forms of vulnerability. That does not address the problem of (the lack of) help-seeking and how you get individuals into the system.

The VVCS go to lengths to promote their service and to provide information that can be useful, but as an (Army) Company Commander I was only aware of the VVCS 2 months before my discharge. If an officer's knowledge is limited (as mine was) it would be much harder for the enlisted personnel. (K135)

The lack of engagement is attributed to a lack of awareness. Only 35% of personnel since Vietnam have accessed DVA services, or in other words, 65% have chosen not to access DVA services or have not needed them.

Maybe they don't want to be in the system and that becomes a problem when we want reliable data. (K15)

There is a perception that the DVA is unpopular but the "loudest voices" are often clients for whom there is a claim for compensation or liability. Compensation issues are often involved in criticisms, especially when the individual has been injured and unable to work. It was noted that it is required by the legislation that the individual be assessed to measure the levels of impairment; it has to be quantified. Often the Gold Card and a TPI pension is the goal and that becomes a complex determination. The key informants suggested DVA's responsibility to simultaneously manage support and compensation was a 'vexed space'. The adjudication process can be difficult (and time consuming) and it is often adversarial in its nature. The legislation is prescriptive but the key informants were firm in their belief that its operation demands a more humane approach.

DVA is undergoing a Veteran Centric Transformation that aims to measure success from the Veteran's perspective as an outcome for the Veteran; rather than as a process measure or transactional measure. (K15)

Issues around help-seeking and treatment have been eased somewhat by the non-liability-health care (White Card), but this does not provide universal coverage. For the former-serving personnel, the unfamiliar, unstructured post-service environment creates a unique barrier to services.

... the fences have been taken down, it's unpredictable and more complicated. Because they have existed within boundaries, being told where to go, what to think and how to act for such a long time they're not sure what to do now they have complete freedom of movement. There are no rules of engagement. They have to make choices and in order to make choices they need to know what is available. (K12)

Non-liability health care has been a substantial improvement for veteran health; access is wide, presentations over a wide range of issues (e.g. depression, PTSD, alcohol issues). There is a full range of services but systemic breakdowns occur, especially:

1. Knowledge of the full range of services available ...the where and how
2. Disability issues and issues around liability/compensation (very vexed).

3. *Dealing with DVA is extremely difficult and claims for compensation can become very complicated.*
4. *Veterans become so unwell, they can't work and income support becomes a significant issue and impacts on mental health. Especially when any sick-leave entitlements are exhausted.*
5. *Multiple DVA forms are often required to access services (income support/health) and it becomes an administrative jungle.*
6. *Outcome is stress and distress. (K12)*

For the former-serving personnel, there are no clear pathways from primary care, through secondary care, to tertiary care frameworks. Key Informants agree that there is tremendous risk of former-serving personnel "falling through the cracks". (K129)

Community services offer varying levels of care (mostly secondary care) and these can be effective but still lack the case co-ordination that will make a real difference. The services are more often purchased than provided and there is little outreach or case co-ordination.

It was suggested the key risk is less about care at the point of contact, and more about the absence of coordinated linkages and pathways between services and planned outreach. The kinds of assertive outreach witnessed in public psychiatry between secondary and tertiary care services is missing (even when veterans come to the attention of the service, there is little assertive outreach on discharge).

Ex-Service Organisations

The key informants could name numerous Ex-Service Organisations (ESOs) that purport to provide services for families and for former-serving personnel, but regarded them with some reservation.

Too often these groups pop up because of a perceived gap in the system. They don't talk to each other, they don't refer, they're competitive and not necessarily providing the right messages. (K134)

There was concern that the former-serving personnel were unaware of which organisation will provide the services they need, and tend to either stick to the first one they find or drop out early if that one did not meet their needs.

There are numerous ESOs out there and they are a disjointed bunch of organisations. They all have certain skills, but they all have their own agenda (often borne out of their own frustrations and perceived gaps in the system. (K135).

Some ESOs are run by people with a particular (vested) interest and they look good on paper, but there is very little oversight and the penetration and effectiveness is rarely measured. (K112)

The ESOs described vary considerably; some are large, some are small, and they are difficult to compare. It is unhelpful to regard them as a homogenous group and they vary greatly in the services they offer, their governance, and their penetration into the ex-service community. Suggested reforms include the need for succession planning, convergence and renewal (many are time/cohort limited). Nevertheless, ESOs are very useful entry points /catchment points for finding former-serving personnel.

They're not all equal. Some are great (e.g. War Widows Guild, and Legacy), and others not so good. But they often serve a purpose. It needs a more global understanding of the role and purpose of the organisation (e.g. the RSL is a meritocratic organisation, slow but methodical, a good source of information and advocacy; but it doesn't often service the needs of the younger cohort). (K15)

Some specific ESOs target acute distress e.g. OVERWATCH AUSTRALIA is a first response organisation formed to assist former ADF members who are at risk or in crisis, and to act as a bridge to other ESO. Organisations (like

‘Soldier On’, and ‘Mates4Mates’) have a high profile, but not much penetration, and their business model seems to change as they search for purpose. While there were reservations, the key informants believe “...there’s a place for them”.

RSL and sub-branches are run on a parish model – loosely connected to the national and state branches, but have more financial capacity than the new ESO due to club revenues. The more traditional organisations (RSL, Legacy, War Widows, Peacekeeper) have a traditional purpose, but may not have the right personnel for the purpose; they are well-meaning, but limited. There are positive ways to engage with sub-branches (RSL) and to help them communicate, market and re-invent their services. But this takes time, collaboration, effort and commitment.

For the ex-service population there is a proliferation of ESO, many of which overlap with one another, but compete for funding and membership. These organisations “... provide important social interaction and connection ... provide social connectivity, self-worth, connect people in with shared experience” (K132), but are often located in specific regions, attract a limited cross-section of the community, and are at cross-purposes with other similar organisations, and the DVA.

The newer entities use social media. They can do harm by 1) creating a view that there should be something wrong with you, you have served in a warzone; 2) a sense of crisis to create a call to action (for their organisation); 3) they can also spread the word among the ex-service population of not to trust DVA: DVA are the enemy, whereas they are the trusted agent. (K15)

There are a lot of service organisations offering various support but there is not a clear awareness of who is responsible for what, nor any over-arching framework in which they are coordinated. There has been a shift to outsourcing and many system gaps exist, for example, veteran literacy.

GPs are a key component but they need to understand the veteran. The cheapest provider often wins the tender and that doesn’t augur well for understanding.

You need to be able to trust the organisation/individual ... they need to be vouched for and there need to be some sort of quality assurance/endorsement. ESOs have a role here as they can do that vetting. (K110)

ESOs in this space are prolific but they would benefit from a stronger partnership with the VVCS. On one side (VVCS) you have a well-funded organisation, with good governance and access to evidence-based practice and professional; on the other side (ESOs) you have organisations that are good at getting people involved, good at spreading the word, good at the social media outreach. (K135)

Interestingly, Southern Queensland is in a unique position:

- RSL Queensland currently have the financial resources to pull all of the ESOs in the region together in order to determine how best to collaboratively serve veterans and transitioning members
- 7th Brigade at Gallipoli Barracks draw the same ESOs together quarterly to work on initiatives to support the health and wellbeing of the current or former serving members.

A number of IT based support tools were identified as being available through DVA, e.g. the ‘At Ease’ website has a range of information. The Operation Life app is an evidence-based support specifically designed to help those who may be contemplating suicide, and to help family members and friends support those who may be having suicidal thoughts or suicide ideation.

Defence Families Australia and family issues

Defence Families of Australia (DFA) was identified as a key body to represent the views of defence families. Its aim is to inform government and the ADF about the needs of the family, and ensure quality of life for all defence families, by providing a recognized forum for their views. The DFA consults with the ADF’s own support agencies,

e.g. the Defence Community Organization (DCO) and the National Welfare Coordination Centre (NWCC), but acts as an advocate, not as a support provider. The DFA engages with a wide range of stakeholders including the service chiefs. The importance of the family as a fundamental unit of support was identified, however there was little evidence of family centred priorities beyond the DFA.

Key informants also expressed concern that families are often not informed of the mental health and wellbeing issues affecting members, which results in the exclusion of families from the care process. Privacy constraints are often cited as the reason for this, but this ignores the key role family support plays in health and wellbeing outcomes.

The services are pretty good in the service, and a lot better than they used to be, but it lacks a context. There should be more focus on what services are available, how to access them and when...and it should be a family focus. That would make a big difference. There is good communication with operational matters, but that thinking doesn't work too well for the individual or the family. (K110)

Families are more likely to seek help than serving personnel, and calls to services saying "I'm a bit worried about X," can trigger a range of supports. The capacity to respond is limited by the systemic organisation protocols, but the situation is much better than it used to be. Nevertheless, many family members will be unable to spontaneously seek help, either through a sense of loyalty to the member (believing they will betray their trust if they "... go behind their back") or through direct instruction from the member not to speak to others about their private affairs (especially their workplace).

Family problems are also integrally linked to geographic relocation and the issues around the availability of services in any given area. There are issues around timing, distance, separation, growing up separately, kids, schools, friends, communities, health and happiness...it gets complex! (K13)

This reinforces the importance of ongoing, regular, non-intrusive but supportive monitoring of mental health wellbeing of both members and their families.

Key observations

1. Services available to serving personnel are comprehensive and responsive, especially crisis response, operational care.
2. The VVCS is highly regarded, but limited in its capacity for outreach.
3. Garrison Health capacity is highly dependent on location.
4. Stigma associated with mental health issues significantly limits options.
5. Help-seeking is constrained by pervasive perceptions of a negative impact on career path directions and deployability.
6. Relevant help-seeking information and access pathways are often unclear.
7. Outsourcing of services (particularly mental health) has been unsystematic, and there is little in the way of quality assurance.
8. Commanding Officers have limited capacity to support personnel in medical care.
9. Medically discharged personnel are more carefully monitored by DVA however many medical conditions do not present for some time.
10. Transition services are poorly planned and poorly executed. This period of change is critical significant and requires better planning, resourcing, and appropriate time management.
11. Increased data sharing in the transition from ADF to DVA would improve service capacity.

12. For former-serving personnel the services provided by the DVA are carefully described and administered through the relevant legislation.
13. There is a widely held perception that the DVA's processes to access services are unnecessarily complex, convoluted, and sometime adversarial.
14. ESOs exist for a wide range of purposes including social connection, advocacy, support, and service provision. While they are a significant component of the landscape, they lack oversight or an overarching framework in which they are coordinated, and sometimes contribute to duplication and service confusion.
15. The DFA is an important advocate for families, but other resources for families are difficult to access or limited by eligibility.

Effectiveness of services

Key informants were asked to comment on how effective they believe services are in supporting personnel and their families while they serve, as they transition from defence to civilian life, and later in their civilian life.

Serving members

It was evident from the interview responses that the services provided are regarded as effective, however there are issues with accessing these services and navigating the system.

For those currently serving, the services are there... they're probably as effective as they can be. But individuals find the system hard to navigate and the 'individual services' seem to have gone. They've privatised a lot of them and they don't respond, or they don't respond in a way that is effective. The 'understanding' is gone and you have to fight the system. (KI11)

Stigma remains a prominent concern when accessing services, (see Section 6), and it was evident that stigma can also reduce the effectiveness of services provided.

Unless you have a serious problem, you just 'shut up'. And you don't tell anyone because news travels fast. The Med Docs will follow you wherever you go. Services must be able to assist without the career consequences, but how do they do that? (KI11)

Comments were made about ADF members "living to deploy" (KI21), and anything that can get in the way of deployability will be avoided, even if it is detrimental to one's health. Early intervention is important, so that members can receive the help they need before their situation worsens. The relative confidentiality provided by service providers 'outside the ADF' affords serving personnel with an opportunity to seek help.

Early intervention is a key part of dealing with these psychological injuries so if we have current serving or ex-serving veterans seeking treatment early due to the trust they have in VVCS and the confidentiality it provides, then this must be seen as a positive. (KI37)

However, it raises the issue of the willingness of service personnel to seek the help when the perceived damage to career pathways remains as a significant barrier to the provision of health services (particularly mental health services).

Several interviewees commented on a tendency for psychiatrists to "over medicate", and this belief is a contributing factor for not seeking assistance from services. This fear, coupled with the stigma associated for seeking help, are significant factors discouraging serving members from seeking assistance, and why, when they do, it is often too late and the effectiveness of the service may be diminished.

The loss of psychologists with the change to more outsourced service providers was reported as a challenge to the availability (and consistency) of mental health services within the ADF. Similarly, it was reported that psychologists are generally under-staffed, and more resources and staff are needed to provide higher quality care for members.

Outsourcing of staff was identified as a significant issue, with key informants reporting that the external health service providers have little understanding of what life is like in the ADF, and with the consequence that service personnel lack confidence in the service.

There is a lack of trust and faith in the system – often members being medically separated will feel 'discarded' and that the system is 'railroading' them out of service.

In addition, the ADF hierarchy makes help-seeking more difficult as the issue of rank is pervasive and the padres, medical officers, and other service providers often outrank those seeking support.

Transition to civilian life

The services provided to serving personnel as they transition to civilian life have been described as poor, insufficient, and in need of significant improvement.

The transition process in general is difficult. It doesn't matter how good the support is when you move, you're still going to lose that shared mission, that shared purpose and shared experience; all your training is about purpose and patriotism. (K110)

Serving members have many concerns about leaving the ADF, such as:

- A complete change to their day to day life, and whether they have sufficient skills to cope in the civilian world
- Lack of support networks – they will no longer be a part of the ADF family
- A sense of failure if medically discharged
- The lack of structure and routine
- Their skills and an employment background may not be useful for civilian jobs.

A dominant theme that emerged from the interviews was that members are not prepared well enough for civilian life, and suffer as a result. So much training and expense goes into turning these men and women into warriors, and next to nothing (comparatively) goes into turning them back into civilians. Sometimes these men and women may have had limited job experience outside of the ADF prior to joining, and as a consequence they are often overwhelmed when trying to gain employment or even to cope with the civilian lifestyle outside of their institutionalised environment.

After they have left (the ADF) how do they know what they are? How do they know where they are? How do they know what to do? You've taken all the structure away! (K11)

For those in transition, they are not prepared nearly well enough. They just want to go and then they find they just don't know what's happening around them...Employment is tough and the transfer of skills is not always an easy switch... I mean in civilian life, who wants a sniper or a machine gunner? I've been told the Airforce do it better, but for the Navy and Army it's a struggle...Moving from a very structured environment to an unstructured one is tough and the truth hurts. (K111)

A number of key informants suggested that much more support needs to be offered to those who transition from the ADF, including maintaining periodic contact after leaving e.g. phone calls to 'check-in' at three, six and 12 month intervals after transitioning.

Transition is a 'croc' – it's the guys in this phase that are committing suicide. They don't have support and they don't know what they're doing. With psych problems it's really bad when you're transitioning. (K128)

Another area of concern is associated with DVA claims, and in particular the delay between being discharged and receiving DVA payments. The process with DVA has been described as lengthy and stressful, but is particularly taxing for those just leaving the ADF.

Hardest bit is on discharge first year – so much to do. Complex. Not sure discharge process is not too procedurally focussed, and offers less individual support. It goes - Health (Tick), com super interview (Tick), and then a civvi administration officer involved to ensure final (tick) that all is good, then farewell. Improvement is already the Final person - but could that officer could be better trained to identify modifiable risk factors. E.g., they note, this person's Leaving motivation, no wife, no job, health issues, etc. Then as appropriate offer 'We have some support services for you. (K122)

A comprehensive operationalised transitions program is required, so that members progress can be tracked during the transition process, and after they have separated from the ADF. It may often be months or years after leaving the ADF that problems arise. This makes it more difficult to make claims to DVA once time has passed, and can make the process more difficult. It was suggested in several interviews that better screening processes needs to be in place as members transition out of the ADF. While this would not identify all at risk members, as many members do not present with any problems until years after discharge, it would aid in determining who may be in need of extra support or follow up:

Comprehensive medical on discharge – so busy – box tick, but really need to sit down and have a care conversation. How are you travelling? This does not happen. (K122)

The transition process can vary depending on how one leaves the ADF, i.e. whether voluntarily discharged or medically discharged. This is important as the type of discharge can impact upon a person's sense of purpose, sense of self-worth, ability to contribute, and ability to support a family.

Transitions from the ADF can be a traumatic experience for those who have served for short careers as well as those with long careers in the ADF. Those leaving at a time of their choosing usually manage this time better than those who leave the ADF at a time not of their choosing, particularly those who careers have been cut short due to a physical or psychological injury and are medically or administratively discharged. (K137)

Whilst there are transition processes in place, there was a consensus that much work needs to be done to improve these processes, which have been characterised as an “information dump.” The transition process needs to include support for employment after service, and the transfer and translation of skills:

It should really be part of the (Man Power) recruitment contract that [service personnel] get everything they need on the way in and on the way out. Man Power manages recruiting for Defence but that business also has the expertise to manage redeployment of workforces, transition and job placement. Some will ‘go well’ and need minimum support, but others struggle. They are moving from a very ‘managed’ environment to a relatively ‘unmanaged’ one. They need to be able to ‘translate’ what skills they have, and what that means for ‘civie - street’ in both the private commercial sector as well as the public sector. It is a lot more than ‘information’...Many of the skills they take to civilian life are transferable, but Defence needs to play a part in:

- *translating that skill, and*
- *placing them in employment (or facilitating the process) (K137)*

We need a stronger focus on inculcating the capacity to be independent, maybe that involves some type of transitional life-coaching and time to do it, say over 12 months from discharge. (K135)

Former-serving members

One of the most frequent criticisms raised by key informants relates to the effectiveness of the DVA claims process, which has been described as causing unnecessary distress to former-serving members:

The claims process itself becomes traumatic, makes them feel invalidated, worthless. (K132)

For many veterans dealing with the DVA claims process is a bureaucratic nightmare and it's often a ‘battle’. It can be so long and drawn out and the process and correspondence so impersonal and confusing that many people just ‘give up’. They feel betrayed and let down. DVA needs a lot of work to get that right. (K121)

This appears to be a particular concern for ex-members who have been medically discharged, as they often have very little knowledge of the DVA processes. It becomes very easy for veterans to feel frustrated by the system and embittered by the experience. Several key informants commented that former-serving members can 'lose touch' very quickly as their sense of purpose diminishes after discharge.

There's no reason to stay in touch with their mates because the purpose is gone. This translates to family problems and employment problems, and then social isolation and mental health issues. (K111)

While the DVA is able to successfully provide a wide range of services, it is regarded as "less friendly and less accessible than ever before", and that:

Now days, one cannot access a case manager consistently through the DVA. No consistent voice to speak to, there's always a different person on the end of the phone (K138).

Furthermore, there is a clear need for the claims process to be modernised and updated:

What is really needed is the modernising of the system ...to be completely digitised. DVA's IT systems needs a great deal of investment to be redesigned and modernised. Significant parts of the DVA system are STILL paper based. The system should not be the problem as it causes time delays, stress and opportunities are lost to support the individual in the system who may not be doing well. Often the system can appear confrontational and it should not be that way. (K137)

There appears to be a lack of resources and support for younger former service members. These young, former serving personnel appear not to relate well to traditional support services, and turn to the ESOs for support.

Concern was also expressed for families of former serving personnel who struggle with the transitional challenges, and the disconnection from the systems that once supported them.

If I could have one single improvement it would be about separations, and the importance of a facilitated discharge that links individuals with a GP in the civilian health system, and that this should include facilitation of mental health as well. This raises all the questions about veteran literacy for GPs, but it would make a big difference. (K115)

Key observations

1. For serving personnel, services are selectively effective. A wide range of services are available, however knowledge and understanding of services and their access pathways are limited.
2. Outsourcing of services has not increased effectiveness, because the external provider's lack of understanding of military issues compromises outcomes.
3. Internal ADF service capacity has been reduced by outsourcing.
4. The stigma associated with help-seeking (especially for mental health related issues) reduces the likelihood of presenting, and the consequent ability of services to respond.
5. Career pathway (and deployment eligibility) limit the effectiveness of services: the dilemma remains between informed care and the potential consequences for employment and deployment.
6. The hierarchy of the ADF adds a level of separation to the help-seeking processes and is a constraint on their effectiveness.
7. The transition processes/programs are largely ineffective.
8. Transitioning ADF personnel are not well placed to re-enter civilian life, transfer skills to civilian employment, or deal with the associated profound culture changes.

9. The transition/transfer of responsibility from the ADF to the DVA requires more transparency, less duplication, and easier access to personnel data.
10. Transition planning and support needs to be in place for a significant period of time (at least 12 months) for more positive outcomes.
11. There needs to be a stronger focus on families in the transition planning.
12. The DVA processes are complex and lengthy.
13. The DVA 'machinery' is particularly outdated and reform/modernisation should be a priority.
14. The VVCS is respected and effective, within the limits of its responsibility.
15. GP training (for proficiency in military related presentations/'veteran literacy') is needed.

Duplication or Gaps in Services

Key informants were asked to comment on any duplication or gaps they were aware of in current services and how these might be addressed, and were also asked to comment on how services could be streamlined in future. Rather than comment on specific gaps (or missing components), key informants often returned to a discussion of gaps in 'understanding', and gaps in 'knowledge', and regarded these as a higher priority.

Gaps/duplications

A primary concern in relation to gaps in services is awareness of the range of services available to both members and their families.

Soldiers SHOULD KNOW what they can get and where they can get it. There should be no wrong door to treatment or support (K137)

There was a widely expressed concern in regard to outsourcing of relevant services, including psychologists, psychiatrists, general practitioners and recruitment staff, and the "lack of military knowledge" among these outsourced service providers. This lack of military knowledge is often a contributing factor that discourages members from seeking help.

There was concern that the screening processes in recruitment lack the rigor to identify those with existing mental health problems, and that the psychological evaluations when joining are limited and easy to manipulate. In other words, it is easy to mislead throughout the screening process about any existing mental health concerns.

Several key informants raised concerns in relation to appropriate mental health training as well as resilience training. While the efficacy of training programs is still uncertain, it is important that serving personnel are aware of signs of mental illness and how to respond appropriately. Dedicated training would also aid in addressing the stigma of mental illness, as well as the stigma associated with help-seeking.

The DVA process has been described as tedious and difficult. Specific concerns were raised in relation to the gap between being discharged (generally/medically) and making a claim and receiving payment:

If you are on a medical discharge you have 45 weeks without work (zero life accountability...bureaucratic nonsense). Needs experienced people who understand the realities. (K11)

Key informants identified the transition from serving in the ADF to civilian life as a significant gap requiring review and resourcing.

The DVA will support you but the general population don't understand the depth of your service and the specialist skill-set that includes. It puts families under stress because the ex-serviceman has to learn a whole new set of skills to survive on the outside. They struggle with networks (the old ones don't exist anymore and the new ones are unfamiliar). They're not good at making new friends and civilian life is foreign ... and that leads to social isolation. (K110)

There were concerns in regard to duplications of services where services become competitive with each other:

ESOs in many cases compete with each other for the same charity donations and should be careful to spend these limited funds where it will achieve best effect rather than competing with or duplicating services already provided by government (DVA) or another ESO. The perceived notion is that ESOs exist where there is a vacuum ...where no services exist...when the opposite is often true (but no-one knows about it!). (K137)

Other gaps in services include support services for families, both when the member is serving and when they transition out of the ADF.

Access to support is there but it's not support for the right things, and the weight of that is borne by the family. When the military meaning is gone, so goes the purpose and that leads to lower self-worth and lower self-esteem. (K110)

Support

The lack of support was reported in the interviews and several key informants commented on the importance of providing effective support for families, stating: *"a happy family = a happy soldier"* (K11). There are gaps in relation to support services offered for families, particularly in relation to ex-wives: improvements for families that were recommended included support when a member is transitioning out of service in terms of finding future employment:

[Improvements] could include educational support for families especially spouse and/or widows to establish them in a career and, tertiary scholarships for serving personnel to assist with their return to civilian life...those sorts of things. (K137)

The key informants also recommended that the discharge process, and the process to make a claim and receiving payments by DVA, is simplified. These processes are reported as being complex and confusing, and many eligible personnel do not know where to go or how to navigate the system. It is important that there are no 'wrong doors' for members, and that seeking help and support when needed is a simple process:

Whoever they make first contact with should open the door through which they are directed to all the appropriate support and treatment available to them. We need to make transition from the ADF as painless and stress free as possible. Pathways need to be closer, seamless, and not competing with one another. Support starts early so the idea of transition should start early, preparations should start as early as recruitment so in the case of DVA visibility of injuries as they occur can be registered and liability accepted well before the point of transition. (K137)

Importantly, improvement needs to be made to the transition process and transition services.

Key observations

1. KIs more readily identified gaps in the capacity of programs, rather than missing elements.
2. Improved support for families is required across the spectrum of service (serving personnel, transitioning personnel, and former-serving personnel).
3. The recruitment process is currently a relatively 'blunt' instrument and lacks the sensitivity to screen for many of the issues that may become problematic.
4. Transition programs/support is poorly planned and largely ineffective.

Barriers

Key informants were asked about their views concerning the barriers to current and former serving members accessing services. They were asked to take into account cultural relevance, availability of providers, employment, functional capacity and degree of ill health. Many of the barriers to accessing services are consistent with the gaps that are present in services, as discussed in Section 5.

Stigma and its impact

The most commonly cited reason for not seeking assistance is the fear that seeking support would have a negative impact on a member's career, and the perception that admitting to a mental health problem, or even that you are not coping, will irreparably harm your career, and result in restrictions affecting employment, deployment and promotion.

Stigma (particularly in regard to mental health) is a significant barrier in relation to seeking help, both for those serving and those who have separated from the ADF. To change the way mental illness is perceived, a cultural change is required in the ADF:

The culture of the ADF is pervasive and difficult to change, but there are conscious steps being taken to be more facilitative and to rise to the challenges. (e.g. the Operational or Op Tempo rotation and respite between deployment is being examined carefully with regard to health outcomes). (K137)

While serving, it is not highly regarded to show signs of 'weakness' and so serving members will generally keep their problems to themselves. Seeking help should not be an end to one's military career. For those that have separated, the perception that PTSD is a sign of weakness is also a problem.

If help-seeking (and the condition) precludes deployment or operational activity, there needs to be a pathway to allow them 'to serve' with dignity. Therefore:

- *reduce the potential for 'lost souls'*
- *be employable*
- *give them something worth living for (K137)*

A sense of pride is another contributing factor, as well as the belief that admitting to a mental health problem is a sign of failure. A number of key informants stated this sense of failure is a major concern amongst members. Stigma also is a predominant concern for women in the ADF, with a view that "it's a man's world" (K18), and not wanting to seem 'less than a man' by asking for help.

Breaking down the stigma of mental health concerns is the biggest challenge for the ADF and the broader Australian community. It requires a consideration of the level of impairment from a psychological injury that can be treated and managed in the ADF, and the pathways for continued employment, and avoiding medical discharge. It is a range of factors that contribute to the particular stigma attached. Most serving personnel want to continue to serve and make a contribution (to be valued) and until we fully understand this, the stigma will remain a significant barrier. (K137)

Complexity of compensation claims processes

The key informants were consistent in their concern regarding the complexity of the claims process in the DVA.

The paper work involved in claims is impenetrable, and the process is endless (with severe consequences for mental health) ... the stress of the CLAIM is hard enough! (K134)

Claims for compensation can become highly adversarial, and claims for the Gold Card are lengthy and demanding. The current vocational rehabilitation option for Gold Card holders is an excellent safety net option for those who want to try to get back to work, however holders who are chronically unwell are not able to utilise it effectively.

Awareness

Key informants identified a lack of awareness and information in regard to support pathways as a barrier to assistance.

*The providers say 'these days people use the internet' – but they only do it because they don't know where to start. If it was more clearly set out/advertised, people might go to the services.
(K114)*

The numerous changes in service provider personnel compounds the problem, by making it more difficult to develop a relationship with a provider.

Barriers to recovery

Barriers to recovery include the 'fight' to hold/be eligible for a Gold Card. A consequence is the disincentive to recover because of the loss of privileges and security.

Conversely, some former-service personnel feel guilty, ashamed or embarrassed if they are granted the Gold Card, but nonetheless don't want to lose the benefit. Entitlement becomes part of the battle not to be regarded as forever incapacitated, which should be the aim of recovery, especially for the younger cohort of personnel.

Key observations

1. The complexity of the claims process and compensation augers poorly for positive outcomes.
2. Gold Card eligibility ought to be reviewed. Many expressed a preference that the Gold Card should be the default position for those who have served, albeit with review of described benefits.
3. Resilience and Recovery should be a (normal) part of training. Resilience programs could be part of a regular routine, combined with a wider expectation of self-care.

Utilisation of other services

Key informants provided comments on the extent to which former serving members utilise other services which related to (a) the knowledge and understanding of available services, (b) the motivation to use services, and (c) the effectiveness of the services in responding to needs.

Knowledge and understanding of available services

There are proven programs with outstanding results, e.g. VVCS. However, there is not a good understanding of the services or their access points. While the VVCS offers a wide range of services, utilisation is still problematic. While the key informants acknowledged that the DVA is getting better at communicating and delivering services, they maintain that it still needs to develop a stronger client focus.

In many cases, the issues surrounding transition and the lack of continuity between the ADF and the DVA was a point of concern.

When you leave you get bundled out and that's the way it is. (K110)

Surely we can put up a program to professionally train a person to live in civvy street, budget, life skills, relationships... (K140)

More generally, the ESOs have traditionally been competitive and not collaborative. Recently the formation of a National ESO Collaboration - RSL, Legacy, Mates4Mates, Soldier On, Phoenix, DVA, RSL Care, KPMG & Noetic (consultancy) - has provided some governance and direction. Also the Alliance of Defence Service Organisations (ADSO) made up of RSL, Soldier On, Legacy, Vietnam Vets Federation, Young Veterans, and others is doing a good job in encouraging collaboration.

The key informants observed that it is important to bring in the best resources to guide early intervention to support mental health recovery in the interests of the sufferers, the family and the children. They indicated that greater communication and awareness on eligibility and the ease of access to the key supporting agencies is needed. Positive messages need to be given rather than more of a bureaucratic approach about who can and cannot engage to obtain support.

It was observed that there are so many ESO organisations that it's impossible to really know what's available and what might best suit a particular individual. There are also only a few ESO that involve the whole family and that is a marked gap.

A word of caution in regard to the ESOs. Many of them have emerged because of passionate leadership, but many of them are suffering in their own worlds. They exist because of a perceived absence of what they want, what they need -. It is a loud and emotive cry, but often one driven by personal agendas. (K135)

The motivation to use services

It was observed that improved communication of the availability (and purpose) of services supports the message of encouraging people to 'put their hand up' and seek help when it is needed.

Being stripped (medicalled out) makes you lose on both sides and makes you question your reasons for enlisting in the first place...a consequence is sometimes they will reject the institution as pay back, and moving on is psychologically safer. (K110)

It was also observed that the older institutions (e.g. RSL) tend to service the older veterans (now the Vietnam veterans mostly). The younger ex-service personnel sometimes join for a while, but then drop out when it doesn't live up to expectations, or they get disenchanted. The key informants expressed concerns about the

proliferation of ESOs, particularly in regard to a central mission usually driven by the founders, and their limited capacity to adapt to the needs of the individual.

It was noted that the average age of those seeking support through the DVA has declined in recent years. This data would suggest that more serving and more recent former-serving personnel are seeking support. DVA data indicates that there has been an increase in claims through the newer legislation (MRCA) which implies that this younger cohort is now beginning to connect with DVA to get the support to which they are entitled.

The key informants were consistent in their view that individuals will go outside the system when there are perceptions of distrust, and there are delays and frustrations within the system. It was noted that awareness is a big issue, as it is difficult to identify and access the right services (in and out of service).

The effectiveness of these services

A number of key informants commented on the recent move by Joint Health Command to a single outsourcing contract using Medibank Health Services, who sub-contracted the delivery of services to other providers. While this model has the benefit of providing a greater choice and more programs, it has other negative impacts on the quality of service provided. The most significant issues are:

- a) the loss of experienced, effective professionals (whose contracts were not renewed)
- b) a reduction in service fee for professional health service providers
- c) a significant loss of experienced professional referral pathways
- d) less experienced professionals involved in preparing care plans.

While there has been some return to on-base psychiatry recently, the long-term impact remains to be seen. The impact for former serving members is largely in regard to the continuity of care, and the capacity of services to provide the quality of care required.

Key informants noted that, while the DVA has made considerable progress, the Veteran Centric Reform program in DVA intends to establish closer links between DVA and the ADF. This initiative will also place greater emphasis on getting the transition right, and ensuring the available services get to those who need support for psychological injuries and illness, and they are provided with early intervention to reduce the potential for self-harm and suicide.

Key informants observed that GPs, while often the first point of contact for treatment in the community, lack an understanding of military health. It was also noted that many private providers don't want DVA clients, even those with a Gold Card, because the payments are lower (below scale) and the processes for payment are slow, and frustrating.

Good providers are saying "no" and vets are feeling let down in the system and out of the system. (K17)

Key informants argued on-line programs lack the engagement required to develop the personal relationship to help people get back on track. Similarly, you cannot run a telephone service and believe it is going to change the depth of despair of persons in need of care.

They don't utilise them enough, it's just a voice on the phone, and someone who might or might not understand. So many things get in the way. We have to be able to individualise and provide personal support. (K11)

Key Informants indicated the need to exercise caution when developing 'apps' that lack an evidence base and may serve to '... just remind one that they are traumatised' (K120).

It was observed that peer group approaches have promise, and are worthy of more research and trials. For example, the Vasey Resilience Centre (3rd Brigade in Townsville) is trialling a 'pre-habilitation' program with enlisted personnel receiving a program of life skills. It has a comprehensive range of programs to raise

understanding and self-awareness, improve resilience, to be more proactive, to help-seek, all of which are known to be steps in the right direction.

Key observations

1. Knowledge of services and pathways for access are unclear and result in poor utilisation and compromise effectiveness.
2. There has been a significant loss of expertise and experience with the outsourcing of services, to the detriment of the ADF capacity to provide support.
3. The outsourced services are less effective and less efficient.
4. ESOs provide useful resources and services, but are compromised by a lack of collective oversight and governance. Efforts to coordinate and enhance services are nascent.

In-depth Interviews

The in-depth interviews were scheduled so that individuals who nominated to attend one of the group discussions for this Review that were subsequently cancelled could still provide their personal accounts of experience to the Review

One interviewee highlighted the importance of study, and the need for better education and greater awareness of the importance of further study when leaving the ADF. A number of interviewees highlighted concerns about the lack of skills and qualifications members have in the world outside of defence. More opportunities for study would be beneficial, particularly in seeking subsequent employment. This is particularly important as most interviewees commented that the lack of skills and opportunities in the civilian world can be a prominent factor in the development of mental health issues:

“In the army you are part of a team, part of a machine that worked. As a civilian your army skills and certs etc. are worthless. People come out from the army and are seen as gods, and then are out sweeping floor.” (ID6)

Another interviewee, a family member who lost her husband to suicide, explained that her husband was sick of telling his story over and over again. This interviewee also explained that she was given very little support and information, as was her husband, and that their children also needed further support. She commented that they needed respite for all of them. Another interviewee also mentioned that children get very little support, especially if they are under the age of five.

Other interviewees commented on the influence of relationships with partners, girlfriends and wives, and the comradeship amongst members. One interviewee highlighted that this comradeship is particularly vital to the mental health of members:

“...someone thought it was a good idea to change the way soldiers lived – there used to be four in a room - you did everything together - if one of us started to show signs of stress, we would pick it up straight away. But now they all live in single room accommodation, no one would see that you are stressed or not coping - it damaged the esprit de corps - the sharing and mateship that was lost was protective previously - if a guy was having a rough time with his missus and he smashed up his locker we would look out for him.....” (ID4)

In terms of relationships with partners at home, one interviewee highlighted that these relationships are often the cause of stress and potentially mental health issues among members. Often young members fall apart if there is relationship breakdown because they have had little experience of love.

“A lot of guys commit suicide over girlfriends...Guys who join the military have never known love before from their families etc., a lot of boys join up who are from boarding school...” (ID5)

Generally, the themes for these interviews were consistent with the themes from the key informant interviews, with the main points being:

1. the system is too fragmented;
2. over-centralisation of services;
3. claims system convoluted;
4. very few services have an outreach charter;
5. transitioning out is too brief and not good enough; and
6. there needs to be emphasises on stability after transition.

References

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