2. Submissions

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

National Mental Health Commission

28 March 2017

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Abbreviations

Abbreviation	Definition
ACMHN	Australian College of Mental Health Nurses
ADF	Australian Defence Force
CO	Commanding Officer
DART	Defence Abuse Response Taskforce
DVA	Department of Veterans Affairs
ESO	Ex-Service Organisations
MEAO	Middle East Area of Operation
NGO	Non-Governmental Organisation
PTSD	post-traumatic stress disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists
VVCS	Veterans and Veterans Families Counselling Service

Executive Summary

The National Mental Health Commission received 102 submissions online, and another 12 submissions from key informants who have been interviewed as part of the review of suicide and self-harm prevention services available to serving and ex-serving members of the ADF and their families.

The submissions have been analysed in relation to the Review Terms of Reference.

Incidence of suicide

Many submissions discussed suicide rates in the ADF (currently serving and in the ex-service community), and there was some suggestions the official numbers under-report the actual incidence.

Some submissions suggested a number of factors contributing to suicide. The most notable of these factors include separation from the ADF, particularly involuntary separation (i.e. medical discharge); dealings with the 'system' post-transition, and the DVA in particular; 'moral hazard' – the inability to live with actions taken (or not taken) during service after leaving the ADF; and an inability to adjust to civilian life.

The discussion illustrates the complexity of the issue.

Range of services

There appears to be little doubt the range of services available to serving and ex-serving personnel, and their families has improved in recent years. However a number of issues were raised highlighting a lack of awareness of the services available, including the much-praised 'White Card'; factors constraining the availability of the services, especially services not directly provided by either the ADF or the DVA; and complaints about the accessibility of services, especially services available at the DVA scheduled fee.

Effectiveness of services

Many submissions focussed on factors limiting the effectiveness of services. The most significant issues include:

- A commonly expressed and strongly held view that the absence of military knowledge by service providers has adverse consequences for the quality of treatment and can have unintended consequences for deployment and employment prospects, especially for serving ADF personnel;
- The adverse impact of commanding officers and the chain of command who foster the stigma associated with mental illness and discourage help-seeking, or who frustrate access to medical assistance;.
- The outsourcing of mental health services by the DVA;
- The difficulty of dealing with the DVA, by itself can be a contributing factor which worsens the distress and severity of a veteran's condition, and in extreme cases, can lead to suicide ideation and suicide;
- The ineffectiveness of efforts to manage transition from the ADF, and the real and substantial adverse impact which transition to civilian life can have, especially if that transition is an involuntary medical discharge; and
- The inadequate support provided to families.

Duplication or gaps

There were few submissions relating to duplication in services, but a number of gaps were identified, including the absence of training pathways for military psychiatrists, gaps arising from the DVA model of purchasing services from private providers, the under-use of trauma informed care, limitations affecting access to the White

Card, the lack of mental health nurse practitioners in the ADF, the poor advertising of the last Defence Abuse Response Taskforce process, and resilience training.

Barriers to seeking help

Three specific barriers were raised in the submissions:

- stigma associated with mental illness in the ADF;
- fear of the career consequences of mental illness; and
- the harmful impact of the ADF culture.

The use of other services

The extent to which ex-serving personnel use services provided by other parts of government, ex-service organisations, the private sector or non-government organisations, was addressed in only a handful of submissions. The discussion was largely focussed on two topics: the Veterans and Veterans Families Counselling Service (VVCS), and the role of ex-service organisations (ESO).

The VVCS was frequently cited in the submissions, and almost universally praised for the quality of assistance provided. One important attribute of the VVCS (and other private or community treatment services) is the confidential nature of the service; currently serving members of the ADF can access the service and receive assistance without the knowledge of their commanding officers or other members of their team. This removes the stigma of disclosing a mental illness and the loss of face (weakness) that comes with other more public forms of help-seeking, and avoids the risk of jeopardising future deployment and employment opportunities.

The role and function of ESO was the subject of numerous submissions. These organisations play an important role in supporting Australian ex-service personnel, but the submissions suggest the real contribution of some ESO is open to question.

Additional related submissions

In addition to the submissions received in response to the formal call for submissions, the Commission also received twelve submissions from the key informants as a means of providing evidence to substantiate the issues raised in the interviews. These submissions are summarised in Section 8.

1. Introduction

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

The National Mental Health Commission (the Commission) was tasked by the Australian Government to conduct a review of suicide and self-harm prevention services available to serving and ex-serving members of the Australian Defence Forces (ADF) and their families. The Prime Minister announced the Review on 11 August 2016.

The full report will be provided by the Commission to the Minister for Defence, the Minister for Veteran's Affairs, and the Minister for Health and Aged Care at the end of February 2017.

The terms of reference focused on six specific issues:

1. The incidence of suicide among serving and former serving ADF members compared to the broader Australian community.
2. The range of services available to current and former serving members and their families.
3. 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.
4. Any duplication or gaps in current services and how they might be addressed.
5. 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.
6. 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

1.2 Methodology

Submissions

The Commission invited online submissions addressed the terms of reference via its website. Two options were offered for lodging submissions:

1) a comment or submission of up to 5,000 characters could be lodged by clicking the submission link; or
2) an existing document (in any format) could be uploaded and lodged as a submission.

Submissions could be made anonymously, and any submissions with personal details were de-identified prior to analysis. As a consequence it was possible for one person or organisation to make a number of anonymous submissions; each would be recorded as a separate submission.

The deadline to complete the Review limited the period for submissions to 25 days, beginning on 2 November and closing on 27 November, 2016. Some submissions were, however, accepted after this date, and the last submission was received on 20 January 2017.

All submissions received were downloaded, de-identified and numbered, and uploaded to a secure online space for review. All spelling and grammatical issues within the submissions were retained.

In total, 102 submissions were received: 38 submission documents were uploaded, and 64 submissions were received via the 'comment' option. The submissions come from a broad cross-section of sources, including current serving and ex-serving personnel, families of people with military experience, and a range of service providers.

The submissions vary in length and form, with some being short paragraphs of personal experiences, and others being formal, publicly available documents. Submissions made via uploading a document were coded as Sub1, Sub2, Sub 3 and so forth, and submissions made via the 'comment' option were coded as TxtSub1, TxtSub2, TxtSub3 and so on.

A submission from the Department of Health, (submission 36) addresses the developments in suicide prevention and the current policy and program responses of the Australian Government. This was not de-identified, and is discussed in the separate Literature Review report that accompanies this report.

In addition to the submissions provided directly in response to this Review, a number of key informants and in-depth interviewees also provided submissions they had made to recent and related enquiries. Twelve such submissions were received, including correspondence to the Department of Veterans Affairs (DVA), ADF Command, submissions to parliamentary enquiries and data on suicide in the ADF. These submissions have been coded ResSub01, ResSub02 etc., and have also been analysed against the terms of reference, and the findings are summarised in this report.

Analysis

The purpose of this report is to provide a summary of the feedback and input from the submissions, not to assess the merit of the submissions or evaluate the content.

All submissions were independently reviewed, and analysed for common themes that related to the six terms of reference using a common set of guidelines. This report presents the major themes and issues identified by this process.

Where excerpts from the submissions are reported verbatim in this report they are presented in quotations marks and italicised.

Most submissions were anonymous. Some submissions include biographical information as context, and where relevant we have provided this biographical as a footnote when quoting from these submissions.

A number of submissions were received from organisations, (e.g. the Royal Australian and New Zealand College of Psychiatrists, and the Private Mental Health Consumer Carer Network (Australia) Limited). Wherever excerpts from these submissions appear in this report the organisations have been identified.

We note no submissions were received relating to self-harm itself, other than in the context of suicide and suicidal ideation.

2. Incidence of suicide

Many submissions discussed suicide rates in the ADF (currently serving and in the ex-service community), and suggested a number of factors contributing to suicide. The discussion illustrates the complexity of the issue.

2.1 Comparing suicide rates in the ADF with the general population

There are conflicting perceptions about the incidence of suicide in the ADF, and a number of submissions compare suicide in the ADF with suicide in the general population to show the significance of the issue. Some submissions, however, noted such comparisons for currently serving ADF personnel were not useful because the demographic profile of this cohort (e.g. predominantly young males) is different to the Australian population.

Some submissions also noted there were certain protective factors for serving personnel which actually reduce the incidence of suicide and self-harm. For example, there are a range of programs and services available which, in many cases, are arguably better than the services available to the general population, and the camaraderie, and sense of purpose and belonging which comes with being a member of the ADF, are seen to be strong preventative factors.

2.2 Reporting suicide

Several submissions questioned the veracity of the statistics on suicide, arguing the data understates the incidence of suicide among serving and ex-serving personnel. Several factors have been suggested to explain this bias.

> *Personal conversations with survivors of suicide and their families tell a story of cover-up of methods of suicide and planned suicides. This usually involves death to look like it was "an accident", such as vehicle accident or drug overdose. This will skew and misrepresent the true data. It has also reportedly been planned so it won't impact on the family's social status, life insurance policies and the community perception. The truth can be hidden in military families. (Sub 4)*

It was also noted that the issue of accurately recording the incidence of suicide among ex-serving personnel is complicated because there is no reliable or consistent means of knowing or recording whether the deceased had been in the ADF.

One submission called for public reporting of suicide and attempted suicide by serving and former ADF members, arguing that ongoing surveillance was essential for assessing the impact of interventions.

> *"Annual statistics of suicide for ex-ADF personnel and both suicide and attempted suicide (as attempted suicide is a powerful predictor of completed suicide) for current ADF personnel must be made public. The data should be stratified by state and territory, age band, gender, service type (Army, Navy Air force), and deployment history. These data should be readily available for current ADF personnel."*
>
> (Sub35)

2.3 Why people consider suicide as an option - risk factors and causation

A number of submissions discussed the reasons why current and former service personnel commit suicide. The discussion highlights the complexity of the issue, and whilst mental illness would appear to be one of the most

important contributing factors, it is clearly not the only cause. Other factors include physical pain and suffering, the trauma of certain life events such as the breakdown of marriages and other significant relationships, and 'survivor guilt' (why them, not me).

Four specific causes (apart from mental illness) are worth noting: separation from the ADF, particularly involuntary separation (i.e. medical discharge); dealings with the 'system' post-transition, and the DVA in particular; 'moral hazard' or 'moral injury' – the inability to live with actions taken (or not taken) during service after leaving the ADF; and an inability to adjust to civilian life.

Separation from the ADF

> *"The military culture places special emphasis on interpersonal relationships, both amongst peers, as well as between seniors and subordinates. As Defence personnel, we are told to 'look after your mates', and the camaraderie that exists within the military is a significant loss to people when they leave. Social withdrawal and isolation are the primary diagnostic features in depression, PTSD, anxiety, and substance abuse, all of which have a very high morbidity amongst Defence personnel, as seen in the 2010 ADF Mental Health and Well-being Study.*
>
> *Unfortunately, the process of discharge and separation from Defence means that people lose social connections (and therefore support) simply because they have left Defence. They go from a regulated and highly structured culture to what can seem to be an [un]regulated and dysfunctional civilian world, in which they may have very few social relationships.*
>
> *What is particularly troublesome is that the separation is often involuntary due to medical reasons, with mental health problems being primary amongst these. Physical injuries are also strongly associated with mental health problems including depression, anxiety and substance abuse, and thus the majority of Veterans will have some form of co-morbid mental health problem, even if it is not the primary problem, and hence these problems are again exacerbated by the loss of social connections after involuntary separation from Defence"*
>
> (Sub 21)[1]

Problems with the 'system'

> *"… my greatest concern is DVA. I am often referred ADF members who are about to be discharged on medical grounds and fear for them as they try and negotiate the DVA system, then they don't get paid for weeks and months. I put all these diggers on suicide watch and get them through but without any assistance or recognition from DVA.*
>
> (TxtSub 16)[2]
>
> *I feel that the prolonged distress of the DVA/COMSUPER process is one of the primary reasons why Australia veterans are committing suicide in increasing rates.*
>
> *Since the introduction of non-liability healthcare coverage for mental health and substance abuse problems, I have seen an increase in veterans coming to see me, which is a good thing; this*

[1] Submission 21 is from a consultant psychiatrist with 27 years service in Australian Army, including deployment to Afghanistan in 2013. He was a 2014 Churchill Fellow who studied Military and Veteran's Mental Health in the US.

[2] A psychologist in private practice working for the ADF since 1981

demonstrates that opening access to services with minimal administrative requirements works in terms of Veterans accessing services.

However, in terms of claims for compensation or liability, there is an enormous amount of paperwork and administration involved in submitting a claim, along with the burden of proof required for this. Each individual injury or problem requires a separate claim form, regardless of whether they are related injuries. Each claim may be many, many pages long. That claim may then be assessed by somebody with only superficial knowledge of the issues involved, and hence rejected, as the claim was not clear, or not understood, by the assessing psychiatrist. These problems are exacerbated by the claimants not understanding what is going on with themselves at the time, and the fact that they are quite obviously unwell when they are going through this process.

[A]ccess to COMSUPER disability support payments is separate to the DVA process and generally involves a repeat of the same assessments and reports [required by DVA]. … the process is incredibly cumbersome, inappropriately administered, and …the silo arrangements between DVA and Commonwealth Super have impacted very poorly on people's mental health.

Suicide is a realistic option for these people, as they cannot perceive that their lives will improve, they cannot see an end to their wait for these 'entitlements', and their lives will just deteriorate further. They have no work, don't feel they have any capacity for work, most likely have alcohol problems, and their lives are a battle with themselves, DVA and their perceived losses. Once their partners or families have left, they consider themselves as broken rejects, and they have nothing else in their lives. Is it any wonder why they wouldn't want to kill themselves?"

(Sub 21)

Moral hazard

"… the political complexity of contemporary wars, compounded by their ongoing nature, often results in moral dilemnas to returning service personnel who face the challenge of reconciling their sense of self-worth with public perceptions concerning the worth of wars fought"

(RANZCP submission)[3]

"In an ideal world fighting a war is when men are fighting men, but the war in Asia changed that concept. When a soldier kills a child, youth or a woman that event stays with him and the adverse effects of that occurrence come to the surface after he is discharged. The soldier as a civilian can't come to terms with this reality of what he has done, and unless given correct therapy will commit suicide or be on a downward, self-destructing spiral.

(TxtSub 20)

Soldiers have drawn the short straw over the last 10 years. We lost over 40 comrades in a shithole, we got most of the job done in that shithole, however in the end it was all for nothing as the Government just packed us up and left.

[3] Royal Australian and New Zealand College of Psychiatrists

The Government and the ADF has sent us to some ungodly places over the years to do some pretty ordinary things, and yet they are not prepared to have our backs when something goes wrong. [Their attitude] …we'll send them but we wont fix them after breaking them …comes to mind."

(TxtSub 64)

Adjusting to civilian life

"Coming home from war to Australia requires difficult mental and physical adjustments for veterans and ADF personnel. Firstly, the world of those who are not in services has moved on … from where the veteran or ADF members left it. The service man/woman expects to return to the world he/she left, but everyone else, family and friends, have moved on to another place.

There is still stigma associated with those who participate in wars – on his return home he found many people who blamed the soldiers, rather than the politicians, for their involvement in Vietnam. Nowadays there are many voices which were against the sending of troops to Iraq and, to a lesser degree Afghanistan. This adds to the mental stresses placed on returned veterans. "

(Private Mental Health Consumer Carer Network (Australia) Limited sub)

The wide range of causes or factors contributing to suicide (or at least suicide ideation) has clear implications for any efforts to prevent suicide; changes are required on a number range of fronts. This is not just a mental health issue.

2.4 Flow on impacts of suicide and self-harm

A number of submissions highlighted the suffering and vicarious trauma experienced by children and partners of service personnel.

"… the families of service people often experience the impacts of service both directly and indirectly and in a manner that is blind to the military system".

(ResSub4)

Furthermore, it was submitted that family members of serving and ex-serving personnel who have been diagnosed with post-traumatic stress disorder (PTSD) are themselves at greater risk of suicide and deliberate self-harm.

3. Range of Services

One of the objectives of this review was to understand the range of services available to serving and ex-serving personnel, and their families. There is little doubt that the range and quality of services affecting suicide and self-harm have improved in recent years.

> *"In focusing particularly on suicide prevention, the ADF is to be commended for its development of a four-level suicide prevention program"*
>
> (Australian College of Mental Health Nurses sub)

A number of submissions provided insights about the awareness of services, the availability of services, and the accessibility of services, particularly for ex-serving personnel.

3.1 Awareness

A lack of awareness about the range of services available was commonly reported in submissions.

> *"As the wife of a defence force member, I feel that there are adequate services available to assist both within the defence and within the community. Management need to know about and support their staff to access these services.'*
>
> (TxtSub 1)
>
> *"Many ex-members, particularly younger ones may not even be aware of where to turn when they find themselves in a bad spot, particularly due to finance or mental health concerns. And once they are in a bad spot, particularly males are unlikely to seek help unless pushed by family or their partner.*
>
> *I believe we need to be much more proactive in this area, as this is where the self-harm and suicide occurs. Prevention is better than cure or treatment. Currently, all of the supports are focused on treatment. Let's re-engage with ex-service people, through email, social media and through family to provide them with regular updates on services, how to access them and provide assistance with contacting these services...encourage them to build a relationship, to build trust with services when they are well, so they are able to call these services when they are not well."*
>
> *(Sub3)*

A number of submissions refer to the apparent lack of awareness of the 'White Card', which provides access to treatment for certain mental health conditions on a 'no liability' basis.

> *"Given that the White Card is for treatment only of mental health conditions, it would be far more effective if it was automatically issued as part of the ADF separation process. The outcome of this would [be] access to appropriate professional mental health care in a timely manner."*
>
> (TxtSub 21)

The lack of knowledge about services is also an issue after discharge, especially as problems often arise long after separation from the ADF, by which stage their family, friends and peers may be unable to understand the circumstances or offer much support.

3.2 Availability

The availability of services is discussed in more detail in the following sections of this report. The shortage of trained health professionals is a particular issue raised in some submissons.

> *"As mental health services for current and former members of the ADF are provided according to the purchaser-provider model, individuals seeking services are limited by the availability of services within their area.*
>
> *Many mental health services in the community are saturated with civilian consumers with sever mental illnesses and may therefore lack the capacity to design appropriate services and interventions for current and former serving members of the ADF and their families. In many parts of the country, including remote areas where many military bases are situated, the extent of specialist services can be extraordinarily limited."*
>
> (RANZCP Sub)
>
> *In the SNSW region, there are 1 of 4 positions filled in the Regional Mental Health Team. There are also positions vacant in the MHPS at Kapooka, as well as MHPS at RAAF Wagga and the MHPS at ACT.*
>
> *How can Defence say it is serious about preventing suicide when the most basic premise surely would be to fill the required anti-suicide workforce positions? Because there is such a shortage of positions the mental health workers spend all of their time putting out bushfires instead of doing prevention work, which is where you get the best bang for your buck.*
>
> (TxtSub 11)

3.3 Accessibility

In their submission to the Review, the Commonwealth Ombudsman advised the Commission it is currently monitoring the issue of veterans' access to health services following an increase in the number of complaints from veterans and concerns raised by ESOs. These complaints include:

- veterans experiencing difficulty locating medical service providers who will accept the scheduled DVA fee, particularly where the veteran is seeking psychiatric, neurological and orthopeaedic services;
- significant waiting periods (once a provider has been located who will accept the DVA fee) given the high level of demand from other ex-service members; and
- having to travel significant distances to have their medical needs met inside the fee schedule, which is a particular concern for those with mobility, mental health and support barriers.

> *"I approached DVA 4 years ago and again 2 years ago for help accessing a mental health program due to ongoing depression (1st diagnosed in 1998 whilst I was serving). Initial contact I was told I didn't meet DVA guidelines for help (wtf?) And the second time I was told I had to find a psychiatrist to diagnose depression and that DVA would not help (this regardless that I had 1st been diagnosed whilst a serving member and that 2 GP's and 2 mental nurses and a VVCS counsellor all diagnosed me as suffering from chronic depression).*

The fact that it can take 6+ months to get an appointment to see a psychiatrist, let alone the cost of the appointment, makes access to mental health care for ex service personnel next to impossible. DVA in general is extremely unhelpful and act in an adversarial manner towards ex service personnel…"

(TxtSub5)

"The scope of mental health issues is huge, and equally large are the different forms of treatment – the government appears to encourage only those treatments that are quick and cost-effective, such as CBT and anti-depressant medication. The state of current Mental Health Care plan provided by GPs, offers vey little financial coverage for treating mental health issues such as PTSD, which requires a more long-term, connection-based humanistic approach (in my opinion). The government and society's refusal to acknowledge that some things take time, and massive amounts of effort and input from a professional therapist is disconcerting."

(TxtSub 37)

4. Effectiveness of Services

Many of the submissions that referred to the effectiveness of services focused on gaps in services or barriers to accessing services, which will be discussed in the following sections of this report.

Other issues relating to the effectiveness of services which are discussed in this section include a lack of military knowledge in service providers, the impact of commanding officers and the chain of command, the quality of ADF mental health services, the outsourcing of mental health services by the DVA, dealing with the DVA, the transition from the ADF, support for families, the quality of suicide prevention and training within the ADF, the evaluation of suicide prevention programs, and the use of medications.

4.1 Lack of Military Knowledge

One of the most common complaints raised in the submissions is the lack of military knowledge among health professionals and some of the DVA services, which, it is argued, has a serious detrimental impact on the effectiveness of services.

> *"The need for culturally specific forms of care can be seen in the US establishment of their own Veteran's Affairs medical system after the Civil War, and in Australia is seen in the Aboriginal Health Services and specific Migrant Resource Centres. Unfortunately, no such culturally specific care outside of VVCS exists in Australia, and whilst VVCS does an outstanding job, it is still an external agency delivering care."*
>
> (Sub 21)

> *"While there is a plethora of [service organisations] claiming they provide counselling services for suicide … and self-harmers, direct feedback from the military family community informs me these services are far from relevant and appropriate as they fail in the cultural considerations of the nature and extent of military trauma and how these experiences are understood by military families. This failing often exists as an inability for the case worker, counsellor or practitioner to understand the cultural nuances and embedded meanings in terms and phrases commonly understood by members fo the military culture. During therapeutic interactions the military client is seldom able to express their interpretations of their experience in a way that is understood by the practitioner, and …an accurate diagnosis and prognosis cannot be made. This all-to-often results in an inaccurate course of treatment … In most cases this increases the gap of ignorance and misunderstanding between military families and the health profession, generating deeper mistrust in the wider defence community."*
>
> (Sub 4)

The consequences that arise because of the lack of military knowledge vary, and include inappropriate treatment for mental illness.

> *"… military-related PTSD bears a number of characteristics which distinguish it from other manifestations of PTSD and which may necessitate alternative approaches to treatment.*
>
> *For this reasons, the mere targeting of fear memories, though it may constitute best-practice treatment for patients with PTSD in the general population, may not constitute an apt approach to the treatment of military-related PTSD.*
>
> *Although evidence-based practices represent appropriate mechanisms for developing treatments for the general community, they do not always provide optimal outcomes for current and former members of the ADF. The use of treatment guidelines developed for broad use in the community may even act to effectively restrict veteran access to appropriate services and interventions because the research base*

from which to draw is limited in a number of respects with regard to military-related mental health issues."

(RANZCP submission)

"Practitioners in this area should have some personal experience of the military and be trained across a range of treatment modalities rather than slavishly adhering to guidelines which regrettably often do not accurately report the limitations of the methodology of the literature."

(Sub 17)[4]

Another concern is the unintended impacts on careers (especially deployment) because civilian practitioners do not understand the ADF systems.

'In Central Melbourne the standard practice for personnel requiring ongoing mental health support is to refer them to external specialists …whose experience with treating military personnel is sometimes non-existent or is questionable. These specialists have little understanding of the military system, so do not understand the implications of the wording of their reports or how their diagnosis and treatment will effect the future employment of the individual.

Therefore they have limited ability to provide support that is nuanced and taking into account that the individual has the additional issue of losing their livelihood as a very real prospect to take into consideration."

(Sub 25)

4.2 Impact of commanding officers and the chain of command

A number of submissions raised concerns about leadership in the ADF and the behaviour of commanding officers, and the 'chain of command'.

"While there are multiple positive steps being made throughout the ADF to support and improve mental health and suicide, there is one area that is extremely neglected: Toxic Leadership in Unit Command. The Army is extremely bad at identifying toxic leadership, and even worse at doing anything about it. …The CO is the …person most responsible for shaping a unit's culture."

(TxtSub 55)

"Within the military there is a great degree of stigma associated with mental health issues. Over the last few years, as the profile of mental health issues has increased, there has been increasing talk around workplaces.

It is obvious to the casual observer that many senior commanders believe that a mental health issue is a sign of weakness; they express about this opinion openly and publicly.

To someone experiencing mental health issues this open discussion creates fear and isolation, as it leads to a lack of trust in the commanders and that they and 'the system' will look after the individual. This

[4] A psychiatrist in private practice with an interest in trauma, who is also a former ADF reservist with many years experience

fear and distrust, based on the very real stigma demonstrated across all ranks of the military, is a major barrier to people accessing services."

The provision of mental health support is a complex one, and while there may be pockets of the ADF where the management and treatment of personnel with a mental health issue is improving there are also many people suffering quietly in parts of the organisation where there is little support, a lack of understanding and no incentive for people in command/supervisory positions to change their attitude and behaviour.

While this remains the case (and there doesn't seem to be anything happening to change it), the effectiveness of any program or support service is severely diminished and people will continue to consider self-harm or suicide as their only solution to the pain they are in."

(Sub 25)

"The work place events of 1992 still haunt me. Two commanders were instrumental in a very significant decline to my mental health. One used bullying and harassment tactics when he knew or strongly suspected that I was suffering deep depression. As a result of his actions, I very nearly took my life. I have contemplated suicide many times since."

(TxtSub9)

"CoC makes fun of those seeking mental health. They joke about those people to other members and those members workmates. It is abhorrent".

(TxtSub 54)

A lack of understanding of mental health among command staff was also raised in some submissions, as well as concerns about the disregard for the diagnoses of health professionals.

"Due to what I can only explain a lack of sufficient training, my troop commander at one [point] denied that I actually had any problem and insisted that the two doctors, one psychiatrist and three psychologists who had all contributed to my diagnosis of depression were actually all wrong and he was right."

"The biggest failing of the system was that the troop commanders input back to my medical and rehabilitation programme people held way too much sway. His negative contributions turned a mid size problem into a large one and negatively impacted myself, my family and ultimately the unit."

(Sub 2)

"My commander told me [today] that he intends to interfere with my health care, strip me of access to my rehabilitation program, and is encouraging me to voluntarily leave the ADF. It seems to me that he would like to strip me of a means to sustain myself, and to drive me into isolation."

(Sub 28)

4.3 Quality of ADF mental health services

Notwithstanding the significant improvements that have been made in the range of mental health services provided within the ADF in recent years, some concerns have been expressed about the quality of these services.

"Defence has made huge progress in improving its early intervention and triage/assessment/therapy services. However, it is under-developed in its quality assurance mechanisms for mental health. It has a set of core competencies for its mental health professionals, but falls short in the qualification requirements for each discipline, and in the focus on the 'quality' of mental health services.

I admire Defence for the major, and very successful changes that it has made to ensure the maintenance, and recovery, of members mental health"

(TxtSub 6)

This particular submission articulated a number of specific concerns:

- the inequitable impact of a freeze on staffing levels for Australian Public Service mental health professionals which has particular consequences for mental health teams which are 'unlucky enough to have vacancies'
- the Australian Public Service mental health professionals may not have actual mental health experience – they may be psychologists with an organisational psychology background, or a social worker with mental health experience
- contract health psychologists can be hired to work in a mental health team with inappropriate qualifications, such as a Masters in Organisational Psychology
- these psychologists are also used for occupational suitability assessments (i.e. trade assessments and suitability to remain employed in the ADF), which reduces the resources available for the mental health team, and more alarmingly reinforces the perception among serving personnel that self-reporting to the mental health team can have adverse consequences for career prospects if the person you consult for mental health issues is also the same person who may assess your suitability to remain in the ADF.

  "Having a separate MH section in the medical file of members is not conducive to doctors and treating team members being aware of any underlying MH issues. Medical docs are medical docs – governed by privacy legislation. All health docs should be readily accessible to the treating team as this can significantly influence treatments and interventions. Continuing to have separate or siloed sections of med docs just further promotes stigma and is a reflection of ADF's organisational angst regarding MH issues.

  (Sub 35)

4.4 Outsourcing mental health services by the DVA

The changing model of service delivery, which has seen the DVA withdraw from direct provision of services to purchasing these services from private providers, has been the subject of a number of submissions. Although some acknowledge the benefits of this approach (e.g. a large pool of providers, service efficiencies, competition, community based services which support integration into civilian life), there is also strong support for the counter arguments favouring specialised services provided by veterans' hospitals, which have:

- specialist staff and consolidated corporate knowledge and facilitated 'on-the'job' training;
- evolving models of care based on clinical observation and assessment;
- continuity of care; and

- structured communication between veterans, community members, health professionals and department management.

A specific weakness of the devolved model is the lack of service coordination.

> *"As the DVA has relied increasingly on the private sector to provide services, adequate strategies have not been developed to compensate for the losses associated with a devolved model such as the decreased coordination of services. The private sector could be better supported via practitioners' networks and/or consortia to facilitate networking, the setting of standards of care and the identification of practitioners working in the area. It is essential that efforts to improve the effectiveness of services provided to current and former ADF personnel be informed by this shifting landscape."*
>
> *(RANZCP)*

4.5 Dealing with the DVA

Many submissions commented on the difficulty of dealing with the DVA, the length of time to process applications, and the need to constantly prove claims, which in some circumstances can even be a significant contributor to suicidal ideation.

> *"There is an increasing body of evidence indicating that delays in claim settlement, inappropriate decisions and unnecessary obfuscation in administrative process can serve to significantly worsen the distress and severity of a veteran's condition."*
>
> (RANZCP)
>
> *"It took four years before my claim was accepted by DVA for PTSD and I received my Gold Card. …*
>
> *I have contemplated suicide many times since my discharge from the ADF. Just to stop the never-ending judgement from family and friends, and to feel the relief of no longer having to wait for my worker's compensation. A way out of waiting, proving I'm not lying, ticking all the boxes ….a way out of feeling guilt and shame.*
>
> *I don't know how it affects others but I do know the wait and the constant judgement by DVA forced me closer to the edge than I have ever felt. I was fortunate enough to have excellent therapists. My clinical psychologist saved my life on more than one occasion.*
>
> *My psychologist refers to my PTSD as 2 separate incidents underlying my illness. A workplace injury was the first, and the second dealing with the bureaucracy of DVA and the ADF.*
>
> *Despite being placed on 'compulsory' rehabilitation by DVA … I was then refused everything requested (all suggested in writing by my psychologist). Yoga to relieve stress (DVA rehabilitation contractor – DVA said NO). Gym personal trainer to increase endorphins (DVA rehabilitation contractor – DVA said NO). Massage for physical therapy (DVA rehabilitation contractor – DVA said NO).*
>
> *I called the DVA contractor my parole officer. That was what I felt like she was to me. What was the point of asking me and my psychologist what I needed to assist in my recovery and then denying it all"*
>
> (Sub 30)
>
> *"The DVA claims process for determining liability in particular the length of time it takes to make an assessment of liability. My experience around this lies within the number of members managed under the ADFRP who, when medically separated still do not have a decision on their claims. This can be due to*

a number of reasons, delay in submission of the claim due to the complexity of the process, lack of understanding of the process and procedure of how to submit a claim and what is needed. Reports of lost paperwork within DVA and denial of the claims due to lack of evidence to support the claim.

If a member is being medically separated from the ADF for their conditions developed from or sustained due to service, then why is there a need to re-prove that you have that condition. This arduous and complex process further exacerbates the member's medical condition and leads to a lack of trust from the member and further hardship by the member and their family. A lack of understanding of how to navigate through the process is a significant barrier."

(Sub19)

"I was unable (and still unable), to deal with DVA, as the questions and forms and reviews kept the hurt alive. I was discharged for psychological reasons but they refuse to admit I received mental health issues after my joining the Navy date, so I walked away from any paperwork as it only, (and still does) upset me.

Dealing with the issues involved with any claims or such only upset me all the more. It was, and is like rubbing salt into the wound. The psychological services continued, and through to this day I still see a psychologist on a regular basis that was arranged through DVA…So I have no idea of what if any support/ compensation etc. I can be offered to me apart from my ongoing Psychological appointments…"

(Sub6)

"I feel that it is the almost punitive process of veterans having to "prove" their illnesses continually and regularly over an extended period of time that exacerbates their symptoms, and therefore creates the mindset and behavioural expectations that if they cannot remain "unwell" then they will lose any compensation or other benefits that they have been given access to.

The mindset of having to 'prove you are unwell' also creates the expectation that this is the behaviour that is required, and thus becomes a form of personal identity - that they are broken and unwell, they have to keep proving it, and that this is how they will be for the rest of their lives.

In short we have a disability based system – patients have to fight to prove they were injured or otherwise damaged by their service, through a process that generally takes a number of years, and this process therefore perpetuates the problems they face."

(Sub21)

4.6 Transition from the ADF to civilian life

Many submissions expressed concerns about the ineffectiveness of efforts to manage the transition from the ADF so that service personnel can succeed in civilian life, and the consequent impact on the person. A wide range of specific concerns were raised, including the psychological transition from being a 'warrior' to becoming a civilian, the impact of the often sudden and unexpected transition associated with involuntary (i.e. medical) discharge, continuity of care, the impact on payments and entitlements, impacts on the family, fear of civilian life, the lack of information and the lack of ongoing contact.

"Soldiers are taught to 'harden up' and be aggressive. This is desirable in the situations they encounter. It is a way of coping that is effective only temporarily. Many soldiers post deployment and service have

difficulty experiencing the normal gamut of human emotions and are troubled by this. It is an attitude that often translates poorly to civilian and family life"

(Sub 17)[5]

Several submissions suggested better, more extensive transition processes to facilitate the transition into civilian life, noting that current transition courses do not "*train you to be a civilian*". Many submissions noted many service personnel 'feel lost' after leaving the ADF, and have no purpose. It was suggested many serving personnel are so institutionalised they are unable to return to civilian life without support. Similarly, many submissions suggested further education is needed for personnel when they leave the ADF, and that more could be done to develop the career prospects of transitioning personnel.

"If someone is leaving they should be de-militarised not just a day transition course. That does not change you back to a civilian – after all they took 3 months just to make you an ADF member before training. My initial training was 12 months all up."

(Sub13)

"In the precise words of one ex-infantry combat soldier from 1RAR I spoke with recently, 'We just don't relate to civilians and can't relate to civilian life'. This veteran described the mental programming a recruit gets from the moment he begins core/basic training where he is taught to automatically think, feel, and act like they are mechanised for war, avoidant of compassion and remorse …

The veteran continues … 'The Australian military should invest at least three months into de-programming their soldiers prior to discharge preparing them to think, feel and act like a civilian'. …He further stated that even though his body tells him he can no longer perform like a soldier, his mind tells him differently – that he is still a combat infantryman up there.' This veteran is my father – a decorated Vietnam veteran with PTSD.

(Sub 4)

It would appear the ADF's determination to discharge a member can be sudden and unexpected, with clear adverse implications for the service member's well-being.

"I am a serving member who recently was given a surprise letter of discharge from the ADF for a medical condition that I have had since 2012.

At the beginning of 2016 I was set for a big year with a plan for my work and life that I articulated to my supervisor in my initial meeting with him. I had finally come to grips with the challenges I faced with my medical condition. I had been provided some very good mental health support through VVCS, which I thought I could now take into the next chapter of my life.

One or two weeks later I was presented with a medical discharge letter from my supervisor that completely devastated my life. That afternoon I was at the Enogerra gym on the brink of suicide….a very quick descent from someone full of courage and motivation to face their new circumstances head-on, to someone who really has been pushed to the brink and does not know how they will continue their life from that day onwards.

[5] A psychiatrist in private practice with an interest in trauma, who is also a former ADF reservist with 10 years expereince

When I was handed my paperwork from my supervisor where was the support network at that point? My boss was there and told me he would support me, but he has a job and other people to manage too.

I learnt over the next few weeks and months that there are people all around. ADF Rehab Manager, Career Advisor, The Transition Cell, VVCS, DVA just to name a few. Where were they when I received my news and my life subsequently spiralled out of control?

Someone should have been there …. someone with a plan, with a way ahead. We can't leave it to the member to reach out as they don't know who to reach out to. This is where we are getting it wrong. This is suicide and prevention and support at the coalface.

A support trigger needed to occur somewhere along the line between the decision by the MECRB and the delivery of the news to me by my supervisor to present the lag in the support that I eventually received."

(Sub 24)

A number of submissions emphasised the goal of transition should be to successfully integrate ex-service personnel into civilian community, and that successful transition processes requires a plan, and a number of interactions with the ex-service member after discharge, including annual reviews. These submissions suggested continuity of service delivery during the transition period is important, and that the ADF needs to ensure ongoing case management and engagement with civilian service providers.

Separation policy should be directed at units to more adequately prepare a member for separations from service. Such policies should contain a plan that the unit and member sign up to. An agreement if you like about what expectations are for each member. Such an agreement could go a long way to assuring that separation from service is a planned event."

(TxtSub 61)

"There is no contact with ex-members after discharge. They are left on their own to contact DVA, MSBS and service providers.

Once they leave the service, they are suddenly on their own with paperwork, forms and applications."

(Sub 3)

"[T]here seems to be poor understanding of [case management] in ADF and certainly is limited to those currently serving. As soon as they discharge – they are dropped like hot potatoes with little transition/handover period to ensure seamless service delivery. Research indicates that the highest risk of suicide occurs in the first twelve months following discharge from service. This needs to be addressed and the ADF needs to look at better ways to engage with civilian service providers."

(Sub 35)

4.7 Support for families

A number of submissions addressed the issue of the wider impact of mental illness on families, and the significant lack of support provided to assist carers, many of whom have their own issues as a result of the demands on them.

"Without a supported and supportive family, the Soldier does not function effectively".

(ResSub4)

I am a carer of a veteran (Army) who suffers from a long list of mental health issues. I've had to go from physical and mental abuse to seeing him with a loaded rifle in his mouth with our 2 year old in my arms, to dragging him out of a car [when] he tried to gas himself. …

At no time has DVA offered me assessment or assistance with secondary PTSD. I have to deal with it, or pay for it, and that's impossible. If it gets to a point where I can't take it anymore, I'm entitled to no assistance…

I should bill back the cost of a 24-7 nurse because that's what I am."

(TxtSub 41)

"Programs are urgently needed to [assist] spouse, partners, children and other family members to cope with family members at risk of mental illness. There should also be a focus on domestic violence."

(TxtSub 50)

"As an advocate for 13 years, and the wife of a veteran of Somalia with PTSD, I saw first hand the stress on partners of veterans and the very few options of help available for those struggling to care for and understand their traumatised partners. Operation PTSD Support was born out of this need and has been active since 2011. We focus on social inclusion, respite, real hands on peer-to-peer support and educating partners and carers of veterans with these conditions.

Many partners become 'Carer fatigued' with over 50% of this group struggling with depression themselves, caused by the long term daily caring for a partner with PTSD and other mental health issues.

Some partners have attempted suicide (some completing it) or are coping with non-suicidal self-harm practices. Many attempts go unreported and veterans (or partners) are sent home from hospital or not taken by ambulance to hospital, and the statistic is never recorded."

(Sub 18)

"We know that for many partners, the issues of self-harm and suicide are real. They live with disturbing anger, misunderstandings, alcohol dependence, depression and anxiety. However there are little programs of support and this includes the private hospital sector, with most relying on support groups run by the veteran groups themselves.

More needs to be done to support partners and children of veterans and ADF members particularly in the period of first returning to Australia after a tour of duty. War zones don't only affect soldiers, with their experiences directly affecting their relationships."

(Private Mental Health Consumer Carer Network (Australia) Limited sub)

The flow-on effects of mental illness can extend beyond the partner and immediate family, and can continue for generations.

"The key point that I would like to make through my submission is that the complex trauma caused to the partners and children of veterans exponentially increases the likelihood of their death by suicide…

If you turn to the Adverse Childhood Experiences (ACE) Study, that shows that the higher the ACE score, the greater the likelihood of death by suicide…

Moreover, complex trauma left un- or poorly treated results in multiple incidents of retraumatisation, and diminishing physical and mental health."

(Sub22)

4.8 Suicide prevention training and commitment

A few submissions questioned the quality of the suicide awareness training provided, and whether the commitment is real or merely lip service.

"I believe the 20 or so minutes of Suicide Awareness Training we sit through at the start or end of each year is not enough training for supervisors/managers and commanders to sort out or prevent issues that could be avoided. This annual mandatory training is good, but not good enough." (TxtSub 48)

"I am a serving ADF member. During my 21 year career, I have undertaken four 'war like' deployments and one 'non war like' deployment. The Army prepared me well for these deployments. I don't believe they negatively impacted my mental health. What brought me unstuck was betrayal from within….

To constantly by subjected to feel good promotional material about how aware and caring the ADF is regarding mental health issues when the reality is that the organisation is callus to the extent that it seems malicious has been damaging to my mental health."

(Sub 1)

4.9 Evaluation of program effectiveness

It would appear from submissions that there is very little reporting or evaluation of mental health programs offered within Australia, which inevitably must impinge on the effectiveness of the services provided.

"It is imperative that the services provided to our veterans are underpinned by a strong evidence base. It is fundamental that veterans can be confident that the services are efficient. It cannot be assumed that the findings from generic studies of service effectiveness and efficiency will necessarily apply to the diverse and unique veteran population. This requires targeted effort."

(RSL Care and RDNS submission)

4.10 The use of, and reliance on, medications

Several submissions commented on the tendency of health professionals to over-prescribe medications for serving or ex-serving personnel who present with mental health issues:

"I've personally found it difficult to have access to a GP who isn't hell bent on giving me medication for mental health issues. Equally hard is finding a therapist who isn't employing a kind of band-aid approach, who is quick to get you out the door with breathing exercises to keep you 'going'.

The scope of mental health issues is huge, and equally large are the different forms of treatment - the government appears to encourage only those treatments that are quick and cost effective, such as CBT and anti-depressant medication…"

(TxtSub37)

A number of submissions also suggested there was a fear among serving personnel about seeking medical treatment and being prescribed medication, because there is a strong perception that taking medication automatically precludes serving personnel from deployment for at least 12 months, or that it will restrict service roles (e.g. handling of weapons).

5. Duplications or Gaps

There were few submissions addressing the issue of duplication, except in relation to ex-service organisations (ESO), which is addressed in Section 7. There were, however, a number of submissions discussing gaps in services, which include training pathways for military psychologists, health promotion and marketing services, trauma informed care, promotion of the White Card and eligibility for the Gold Card, mental health nurse practitioners, issues facing females in the ADF, and resilience training.

5.1 Training pathways for military psychiatrists

Two submissions raise the decline in employment opportunities for psychiatrists in the ADF, and the absence of established training pathways for military psychiatrists and the consequences for the quality of care provided by the ADF and the DVA.

> *"…there has been a significant decline in employment opportunities for psychiatrists within DVA and the Department of Defence, and there are no uniformed psychiatrists within the ADF at all."*
>
> (RANZCP)
>
> *"In my opinion, one of the primary reasons for the failings of the current Mental Health (MH) services for ADF personnel and veterans is the lack of both a formal training pathway and then employment for psychiatrists within either the ADF or DVA systems. This is a significant issue because there is NO form of training program or specialisation for military psychiatry. This has significant implications as during training, no psychiatry registrars can access specialised training in terms of military veterans MH.*
>
> *I … feel a significant part of the problem has been the ADF has no uniformed psychiatrists within its ranks.*
>
> *In stark contrast, the US military has specific roles and positions for military, and dedicated programs for their training, and hence provides an environment where they can gain the clinical and organisational experience they need over a number of years in order to provide an effective psychiatric service"*
>
> (Sub 21)

5.2 Health research, skill formation, promotion and marketing of services

The RANZCP argues there are a number of significant gaps in system as the DVA moves to a purchaser-provider model of care, including:

- declining research and the lack of a coordinated research model related to ADF mental health issues; and
- less coordination of private sector services.

> *"Without knowing how to access care, there is no overarching system to guarantee service provision. Health promotion including the marketing of available mental health services is therefore absolutely critical to ensure that individuals do not 'fall through the cracks'"*
>
> (RANZCP sub)

5.3 Trauma informed care

The Australian College of Mental Health Nurses (ACMHN) argue Australia's mental health systems have a poor record in recognising the relationship between trauma and the development of mental health conditions, reflected in a lack of awareness and education about trauma-informed approaches within practice and service settings.

The College recommends the ADF and its personnel seek to better understand why a trauma-informed care approach is important to prevention of self-harm and suicide, and explore how such an approach can be implemented across the entire course of service, from training, through to deployment, upon return from deployment, and upon exiting the ADF.

> *"For example, rather than focussing specifically in mental health providers and on post-deployment personnel in a 'diagnose and treat' approach, all health personnel … employed by the ADF or delivering services through the DVA should be trained ina trauma informed approach. Prevention opportunities exist at all levels of illness severity and at all points throughout and following a member or form member's service."*
>
> (Sub 33)

The College argues greater education and action is required at all levels of the ADF about the various responses to trauma and when to seek help.

5.4 The 'White Card'

The introduction of the 'White Card' is widely regarded as a worthwhile improvement that helps to overcome some of the barriers to help-seeking for a number of specified conditions such as PTSD, anxiety disorder or depressive disorder. However, in its submission the RANZCP argued the White Card is not well-advertised, and still requires considerable paperwork to access.

> "… the current system of ex-member application for treatment only White Card is a barrier to timely mental health treatment when needed….it would be far more effective if it was automatic issue as part of the ADF separation process. This would mean, al personnel who separate from the ADF would have a treatment only White Card for mental health conditions. …all ex-ADF members would know regardless of their financial state, they have access to appropriate mental health care and DVA would have a roll of all ex ADF members"
>
> *(TxtSub 21)*

The ACMHN also argues the range of conditions for which veterans can access health services is too limited because the veteran must have an 'approved' mental health disorder.

> *"This is a missed opportunity for prevention for veterans who have perhaps recently begun showing symptoms of trauma, but whose symptoms have not yet reached a level of severity indicating specific diagnosis. Access to specialist health services through DVA should not require a specific diagnosis of an 'approve' mental health disorder. Making services also available to veterans who may have begun to show signs of trauma (for example, a veteran whose family have recently started to become concerned), may potentially prevent symptoms from becoming more sever and shorten recovery time."*

They advocate expanding the eligibility criteria for access to specialist mental health services to incorporate symptoms of trauma, where PTSD, an anxiety or depressive disorder, or alcohol or substance abuse disorder has not yet been diagnosed.

5.5 Mental Health Nurse Practitioners

Another gap raised in one submission is the use of mental health nurse practitioners in the ADF.

> *"[The] mental health service needs to be flexible, readily available and confidential. ADF is the only organisation in Australia that provides on-base primary health care services to a large group of personnel.*
>
> *However, in stark contrast to this service provision is the lack of Mental Health Nurse Practitioners within ADF. To date, ADF does not employ mental health nurse practitioners. [The] lack of such specialist service is a huge concern for ADF and its members. ADF (Joint Health Command/Medibank Health Solutions) does not appear to have an understanding of this role and therefore does not have the ability to take advantage of the nurse practitioner role.*
>
> (TxtSub 30)

5.6 Issues Facing Females

A number of submissions pointed to gaps in services for females, in particular in relation to experiences relating to abuse. Whilst the Defence Abuse Response Taskforce (DART) process was referred to, evidently many people were not aware of the initiative, and others believed they were not treated respectfully when attempting to speak about abuse after the initiative had finished.

> *"I note that over 600 people recently responded to an Australian Facebook question "Did You Miss the Last DART Process". As you would be fully aware it was not advertised by your government in rural and country areas. I personally know of over 200 ex-veterans who missed the last DART due to not being aware of it. If you care about your Veterans and Personnel you are the Minister for, you would get behind and support a new form of DART. Our child knew nothing of the last DART and upon applying was told too late."*
>
> (Sub10)
>
> *"I would like to thank the Government for introducing the DART process then advertising it so badly then treating us like shit for not being aware of it or the ramifications of an "out of date" claim. You people are a joke. Acknowledge the sexual abuse then think that a well worded letter will fix it."*
>
> (TxtSub31)

Whilst many submissions referenced stigma as a key barrier to accessing services, this was not discussed directly in terms of gender, but rather as a problem faced by all personnel.

5.7 Resilience Training and Prevention Measures

A common theme that emerged from the submissions was the need for more preventative measures for suicide and mental illness, and the need to further educate recruits about what to expect before joining or as they join the ADF. It was suggested many people enter the ADF with little to no resilience training or awareness,

> *"To prevent suicide and self-harm, the best way is to provide early education to ADF members and their family members before they going to battle field, or even before they making the decision to join ADF. As being a member of ADF, it is an obligation to participate in real war in battle field. Generally, Australia is a peaceful country compared to lots of other countries in the world. People in Australia enjoy a life without war, or without bloody human being killing environment in daily life, which is a mandatory to military members in the real war. Even the movies in the cinema or in website are classified to protect*

children, avoiding violent action like killing people. On the other side, young people just above 18 years old (still teenagers, or still very young people) are eligible to join ADF. Young ADF members are suffering big psychological pressure when they are in the battle field and realise human killings are real. Therefore, sufficient and good education before joining ADF is critical."

(TxtSub52)

The need for resilience training specific to the ADF experience was emphasised, delivered by ADF personnel who have a deep understanding of ADF life, particularly as (it was argued) there is a tendency to avoid generic training programs.

"Programs should be developed with input of veterans and if possible run by veterans. Programs should also be developed for any serving member who is posted in a combat zone that will work on resilience and also assess and offer appropriate support.

(TxtSub50)

One submission supporting the need for resilience, from a serving Navy chaplain, expressed concern that the current approach to suicide prevention in the ADF was not working because it was normalizing suicide as a legitimate response when things go wrong.

"I'm a current serving Navy Chaplain posted to the Sydney Area. I present the following submission as personal opinion based on experience and observation and as one who deals with the aftermath of completed suicides. Chaplains are the 'coalface' of mental health issues in the ADF, we deploy with troops and we serve at sea on ships. Firstly we are not winning the war against self-harm and suicide, whether as a Nation and also as a Defence Force. Suicide is on the increase in society and in the ADF and yet we have removed the stigma around mental health and continue to do so, and we brief people to the point of exhaustion around mental health and where to got help. So, why is it on the increase? What we are currently doing is not working.

I believe, as in society we have removed the stigma so much that we are almost normalising self-harm and suicide as legitimate responses when something goes wrong in your life. We are also removing personal responsibility from individuals as we claim them to be ***victims*** *of depression, anxiety, stress, relationship breakdown etc. We are de-powering young people in the ADF to build resilience. Self-harm and suicide are wrong and need to be called out as such. Why don't we do this? This behaviour should not be normalised as a response to having a crisis or problem in your life. … What we are doing at the moment is not working in the ADF. I would expect the ADF to have a lower completed suicide rate than general society (due to our care programs), but I don't think this is the case. Last weekend the Duty Sydney Area Chaplain death with yet another completed suicide and of course one is too many."*

(Sub 34)

6. Barriers to Seeking Help

Many of the issues discussed so far can also be characterised as barriers to help-seeking, and they will not be discussed again. This section discusses three specific barriers raised in the submissions: stigma associated with mental illness in the ADF; fear of the career consequences of mental illness, and the harmful impact of the ADF culture.

6.1 Stigma

The most common barrier to seeking help is the stigma associated with mental illness, especially within the ADF.

> *"It has long been known that if a serving member reports symptoms of PTSD he/she are treated by the Army like lepers. So they hold everything in and slowly sink into …depression, and take alcohol to dull the senses."*
>
> (TxtSub 28)

As a consequence of stigma, a number of submissions advocate specific responses including the use of confidential opportunities to seek help, including online platforms, and a zero-tolerance of stigmatising language where emotional responses to traumatic experiences have been expressed.

> *"Mental ill-health often onsets in early adulthood and mental illness is a particularly strong risk factor for suicide so it is important to deliver appropriate and evidence-based programs and services to these populations within the Defence Force. There is a need to consider the role that online technologies can play in providing suicide prevention and mental health services to current personnel and veterans. There are a number of benefits in early detection of risk and providing treatment through a confidential platform which combats stigma around mental health issues and promotes help-seeking."*
>
> (TxtSub 3)

6.2 Fear of career consequences

A significant barrier preventing access to mental health services and discouraging serving personnel from seeking support is the belief that disclosing mental illness will adversely affect prospects for employment and deployment, and result in an automatic 'downgrade' or demotion.

> *"In my opinion the mental health services offered by Defence and the wider community are more than sufficient. I feel the problem exists when members experiencing issues do not self-report for treatment. There is massive stigma within the defence community that is you have had previous mental illness, that the flow on effects will prevent promotion. The common term is career suicide. It only takes one story to be circulated where this has occurred (be it factual or not) and members will be significantly influenced against self referral."*
>
> (Sub 5)[6]

[6] ADF combat engineer who has been deployed to Afghanistan twice and is now studying to become an army psychologist.

"We are being told to seek mental health support early, and told that seeking support will have no impact on our careers. However, some personnel who have sought mental health support early have had their future careers, postings and transfers jeopardised by decision makers because they sought mental health support. …

It is clear that senior leadership are trying to foster a culture where we can and should be open about our mental health; however, the reality is we can be disadvantaged when we seek help. I am in a position where the psychologist and psychiatrist tell me I'm fine, normal and that I don't need treatment, but then told by medical (AvMed) that I am medically unfit to become a crew attendant. I have been cleared of having issues with my mental health and Richmond medical have not recommended a way forward to clear my Med 4 status…"

(TxtSub40)

6.3 The ADF Culture

The ADF culture and its impact on self-harm and suicide and was raised in many submissions. The issue is complex and multi-faceted, and factors which in some circumstances can be seen to prevent self-harm and suicide can, in other circumstances, be barriers to help-seeking or contributing factors to the risk of self-harm and suicide. Some of these cultural factors raised in the submissions include an intolerance of weakness, and concerns about letting your mates down.

"The 'heroic' nature of military service is evidenced by the wearing of the service uniform, the medals and the social status. … weakness is not well accepted or tolerated as heroes are rarely weak or unfit."

(Sub 4)

"Walking into a room crowded with soldiers and asking [to] see a psychologist was one of the hardest things I have ever done. It was a public admission of weakness; that I was unable to pull my weight and was letting the side down."

(Sub1)

"Speaking from experience the toughest hurdle for a service person to face is his/her own fear that they have a mental health problem….The inhibiting factor that prevents a person seeking help is to be tagged as having a mental illness and therefore being thought of as weak."

(TxtSub 19)

Other aspects of the ADF culture, such as verbal abuse, time away from family, and frequent transfers and rotations across the country, are also described as a contributing factor to self-harm and suicide in some submissions.

"The Defence organisation will reap what it sows. …if we verbally abuse our people in training, why are we then surprised when they become abusive in relationships? The wife then leaves and then you have a suicidal member."

(TxtSub 12)

Army has a culture that nurtures the growth of mental health problems. Time with family, friends etc is taken away from us in the name of training. That is a necessity to maintain a high level of competence in our craft. But when field exercises are over, our commanders seem to forget that for 7 months of the year we've been away, and [they] want to put on family BBQ, or a dining in night, or increase numbers

in the duty room … and these are all on the weekends. Commanders seem so out of touch with what their troops are actually doing. To our commanders its 'just one weekend', but to us its just ANOTHER weekend that we've lost….for nothing. …Army is destructive. Toxic. An abusive relationship."

(TxtSub 58)

"The lack of continuity of care engendered by the routine posting of ADF personnel to different parts of the country … may aggravate the difficulties individuals face in overcoming stigma."

(RANZCP)

7. Use of Other Services

The extent to which ex-serving personnel use services provided by other parts of government, ex-service organisations, the private sector or non-government organisations, was addressed in only a handful of submissions. The discussion was largely focussed on two topics: the Veterans and Veterans Families Counselling Service (VVCS), and the role of ex-service organisations (ESO).

7.1 VVCS

The VVCS was frequently cited in the submissions, and almost universally praised for the quality of assistance provided.

One important attribute of the VVCS (and other private or community treatment services) is the confidential nature of the service; currently serving members of the ADF can access the service and receive assistance without the knowledge of their commanding officers or other members of their team. This removes a number of the key impediments to using the services offered in the ADF, especially the stigma of disclosing a mental illness and the loss of face (weakness) that comes with other more public forms of help-seeking, and concerns about jeopardising future deployment and employment opportunities.

7.2 Ex-Service Organisations

The role and function of ESOs was the subject of numerous submissions. These organisations play an important role in supporting Australian ex-service personnel, but the submissions suggest the real contribution of some ESO is open to question.

The growth in the number of ESO in recent years is largely seen to be in response to failings (actual and perceived) with accessing services via the DVA. ESOs also have a number of advantages as providers of services to veterans, including suicide and self-harm prevention services:

- the natural bonds of support and kinship developed during service continue long into civilian life, and the evidence seems to show veterans are most receptive to peer-to-peer support;
- they have an extensive geographical footprint across Australia, including in parts of regional and remote Australia; and
- they have a demonstrated capacity to bring added resources (e.g. financial resources, a wide range of health and welfare services, and advocacy services) to assist veterans – without this response the landscape of veterans services would be much poorer.

Nonetheless, as a number of submissions have suggested, there is clearly room for improvement. There would appear to be opportunities at least to make ESO more efficient and accountable.

> *"The not-for-profits are competing for funding for their very existence. Therefore military families are viewed not as people, but as dollars. Each new client is worth a certain amount in funding, and each outcome (especially for employment services) is worth an injection of funds."*
>
> (Sub 4)

8. Additional Related Submissions

In addition to the submissions received in response to the formal call for submissions (discussed in Sections 2-7), the Commission also received twelve submissions from the key informants as a means of providing evidence to substantiate the issues raised in the interviews. These submissions are summarised here.

8.1 Incidence of Suicide

These submissions consistently argued the numbers of individuals affected by the psychological injury of war, who were as a consequence at risk of suicidal behaviours, far exceeds the number who sustain physical injuries. Moreover, the nature of modern warfare where the danger to civilian life and the uncertainties of who is friend and foe are much greater, increases the risk of psychological injury. Two submissions emphasise the need to heed the lessons from previous conflicts.

Three submissions provided detail on the numbers of suicides in the ADF (ResSubs 2, 5, and 11). One submission provided the numbers of suicides within the ADF from 1985-2015; the data included gender, force arm and history of deployment from 2000. This data showed the age-standardised rate (ASR) of suicide for males in the ADF matched or exceeded the general population data in just two calendar years in the fifteen years to 2015 - 2001 and 2011.

Three submissions pointed to the fact that psychological injuries from deployment to conflict zones far outstrips the numbers of personnel who sustain physical injuries, and that these conditions can manifest long after the deployment/s (ResSubs 1,2, & 3).

One submission provided evidence that shows there is a positive relationship between cumulative trauma exposure and likelihood of suicidality (ResSub 6). This submission also provided evidence on the effect of poor communication, lack of social support, dysfunctional organisational culture (where bullying and harassment occur) and dysfunction leadership in the workplace compound the effects of exposure to trauma.

One submission (ResSub3) pointed to the high and sustained tempo of the ADF since 1999 and the increasing use of the ADF by the Australian Government to "employ broadly and rapidly in support of national strategy and policy". This broader utilisation, the submission argued, reinforced the likelihood that in future operations, the numbers and complexity of injury and illness, particularly psychological injury, will increase.

This is an important consideration in relation to the ongoing investment needed in suicide prevention for serving and former members of the ADF, especially if, as is likely, future Australian Governments will require rapid and agile responses from the ADF.

8.2 Range of Services, Effectiveness and Duplications and Gaps

A common concern raised in a number of the submissions was the loss of specialist mental health capability with both the ADF and DVA and that the care available was neither evidence-based nor optimal (ResSubs 1, 2, 3, 4, 9 & 10).

A few of the submissions also spoke of the capacity of Joint Health Command to provide clinical excellence and quality assurance given the other roles it has to undertake in planning and decision-making.

> *"… the fragmentation of healthcare delivery across the ADF and DVA remains the long-term structural problem. At present, the contracting model that is separately put in place by Defence and DVA creates schisms … Despite the best intentions, a federally directed system will not address the nature of healthcare through state based health services who are often the ultimate providers of services to the ADF and veterans.*

As a consequence, there are too many gaps for people to slip through. The ability to develop networks of health providers skilled in veterans health issues is consequently difficult to implement." (ResSub9)

"Many practitioners and service (providers) have little or no expertise in the area of traumatic stress including the treatment of those with physical injuries". (ResSub2)

Other submissions also highlighted the need to better identify individuals with disorders and maintain them in treatment that in order to make a difference in treatment outcomes. Treatments need to be evidence-based and comprehensive.

One submission (ResSub2) argued *"…the development of intervention programs to address subclinical symptoms in the post deployment environment should be an important priority."* The submission also explains that early intervention could minimise the emergence of disability, thereby reducing or minimising the impact on the individuals capability.

Engagement of the entire family was considered to be of particular importance, and that without a supportive and supported family the soldier does not function effectively. One submission notes that *"families carry the greatest burden of support for injured ADF Soldiers"*, and that it is also important to recognise the ADF as a "*secondary family"*.

Another submission (ResSub7a) called on DVA and Defence to work collaboratively to educate families and teach them how to recognise if a loved one was suffering from a mental illness and ensure they are provided with relevant information.

The rehabilitation of those service personnel who are physically injured must include psychological assessment and treatment (ResSub1, 2)

Finally, two submissions draw attention to initiatives and approaches in other military forces. The first (ResSub1) advocated for mandatory Psychological First Aid following critical incidents as opposed to critical incident stress debriefing. The submission highlighted the US military's incorporation of a 'BICEPS' model and advocated for an extension of the ADF's "Keep Your Mates Safe" initiative where junior NCOs are trained to identify predictors of suicide in their men.

The Canadian military's approach to mental health and suicide prevention was highlighted as a model for the ADF and DVA. Following the Rwanda deployment, Canada revitalised its mental health services and approach. It has established a properly staffed expert workforce of mental health professionals in uniform. This group develops and directs veteran's health services at the provincial level. Uniform assessments, treatments, and quality assurance has provided better standards of care, smoother transitions and timely and adequate follow-up. The establishment of common evidence-based assessment and networks of clinicians and providers were seen as steps toward adoption of the Canadian model (ResSub10).

8.3 Barriers to Seeking Help

A number of the submissions point to the challenging reality that many psychological injuries manifest long after the person has returned from deployment and, in most cases, left the ADF. The veterans of the Middle East Area of Operation (MEAO) over the past 15 years, require the provision of 'optimal care'.

"Post deployment syndromes need to be anticipated and both the question of causation need to addressed by research as well as establishing treatment programs to assess and thoroughly treat those affected". (ResSub2)

A related point made in this submission was the growing body of knowledge on the neurobiology of PTSD, and in the context of the MEAO conflicts, the emergence of mild traumatic brain injury and PTSD. The access to expertise and evidence-based programs is currently very limited.

A number of the related submissions (ResSubs 1, 2, and to a lesser extent 3) were strongly critical of the way DVA responds to psychiatric claims.

> *"The process of recognition by the DVA of an individual's psychiatric diagnosis/es is for many ex-service men/women a grueling, prolonged, invalidating and dehumanizing experience. … many veterans feel that they are viewed by DVA as trying to cheat the system until proven otherwise. (Among) The majority of veterans and advocates (whom I have contact with) the impression is that a steadily increasing proportion of claims seem to be proceeding to the Veterans Review Board and the AAT, which indicates that the DVA are looking for reasons not to provide compensation rather than ways to support their clients." (ResSub1)*

Another factor discussed in submissions that is seen to be important to a soldier's recovery is the role of commanders and clinicians. Commanders are responsible for providing a supportive environment within which performance and success can thrive, and should develop relationships with health providers to maximise their ability to support, rehabilitate, and educate, their soldiers.

> *"…. the commander is a critical component in the decision-making process that ultimately determines the soldier's ability to return to being as functional and as capable as they were before the illness or injury". (ResSub 3)*

The relationship between clinicians and commanders is also important because the clinician provides advice to command on management of soldiers, particularly if they are at risk to themselves or others.

> *"the interaction of shared responsibility between a clinician and commander is vital and will often determine the effectiveness of the intervention provided from the soldier's perspective." (ResSub 3)*

8.4 Use of Other Services

The network of ESOs is not structured, not operating collaboratively, inconsistent in communications and not necessarily skilled to provide effective care and support for veterans and their families.

Efforts to develop more strategic and collaborative approaches were outlined in one set of submissions (ResSub7a-c). These submissions also spoke about the need for tailored employment services to enable more ADF people transitioning out to attain and retain employment.

8.5 The Nation's Obligation

A few submissions referred to the 'covenant' or compact that exists between the national government and the military, and the military and its soldiers and personnel. In essence, this is the moral obligation on government (and the community) that sends its military into conflict zones, to provide a better standard of care for those who have served than is available to remainder of the community who have not. The message from these submissions was clear: this covenant is not presently honoured.

> *"It is my feeling that if we are going to be comfortable as a government and a nation sending our young men and women overseas where many will become permanently injured and some will not return, the we need to make similarly 'hard decisions' regarding funding the best possible care for them on their return". (ResSub1)*

Other submissions highlighted the need for longitudinal health surveillance and ongoing independent evaluation to ensure that those who have served in the period since Timor in 1999, are provided with timely, effective care,

and that given the general concerns about mental health services in Australia, additional services and capability have to be created for these veterans (ResSub 1, 2, 8, & 10).