AFOM
Australian Families of the Military Research and Support Foundation Ltd
Never Forget

Patron: John Cantwell AO, DSC Major General (Retd)
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Senate Standing Committee on Foreign Affairs, Defence and Trade,
Parliament House,
PO Box 6100
CANBERRA ACT 2600

Dear Committee Secretariat,

The Australian Families of the Military Research and Support Foundation is pleased to have the opportunity to make a submission to the Senate Standing Committee on Foreign Affairs, Defence and Trade Inquiry into the mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment.

In this submission, we respond to the terms of reference a, b, c, d, f & j.

Please find enclosed the submission.

Yours faithfully,

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Executive Summary

Purpose of writing this submission

The Australian Families of the Military Research and Support Foundation (AFOM) works with both current and past Military families. We have seen first-hand the effects of mental health issues on the serving member, their partners and family, their friends and their communities. We work to improve not only their circumstances but also the way in which the systems and processes that are supposed to support them function. We believe this to be an important and highly desirable Inquiry and wish to thank those that brought it about.

Methodology

AFOM Directors and friends have been given information and personal stories to them from current and past serving members, their family and loved ones, over long periods. We investigated the information to see how we could best help. We have used much of that information in this submission.

From that information, we have investigated the processes and support systems for the member and the family. We have also researched and published papers on issues around the partner and family and the relationship between outcomes for the member and the family.

For this submission, we used previous reports on this subject, government and non-government, peer reviewed journal articles, and related articles that demonstrate our statements. We have used local and global assumptions of mental health and the mission, and corporate governance statements of the appropriate Departments, to ensure as much as possible that they are connected with our findings.

Findings

Despite previous inquiries and reviews into these issues, there does not appear to have been any major changes at the coalface. The only changes seem to be to add another layer within the already multi layered systems. Defence Community Organisation (DCO) for

example, has been reviewed and restructured and had more money put into it; however, the services at a local level have diminished. The money appears to go into more bureaucracy and more restricting rather than the person centred approach that is required. It even replaced the original meaning of DCO tenet with one that discounts any responsibility for the member's Family and is in conflict with the former ADF Family Support Policy (DI (G) PERS 42-1) and the instructions of the Committee of Service Chiefs. We found that this sort of system is yet another Silo within large departments; we believe it detrimental to the members and their families who require help and support.

These systems appear to have produced more convoluted processes for the member and their family, to get help and support when needed while still in the services. While in many cases these processes have added to the stress, particularly during transition and after they have left the services, even with the direst consequences.

The member and their family have to go through many processes and through multiple systems to gain any help and/or advantage for themselves and/or their family. The systems and processes require boxes ticked and sometimes re ticked. There are even appears to be silos within silos, where a group in one department will misplace or not tick the correct box with paper work and the other group (within the same department) cannot move any further with a claim, complaint or other required process. These errors go back to the member and/or family member who then have to start over again.

Conclusion and Recommendations

We have a page of recommendations in detail addressing the Terms of Reference a, b, c, d, f & j. Rather than repeat them here, we are using an overall view of conclusions and recommendations.

While we have not addressed homelessness under the terms of reference we believe that the systems and processes that many members and their family endure can be directly and indirectly related to homelessness and even worse suicide. Moreover, we believe that the systems and processes are to bear the responsibility for most of the issues found in our submission. We have found the majority of staff to be mostly friendly and helpful; however, they are bound by the system, which can be inflexible and complex.

This major area needs changing. The member/family member's should be the number one priority. The system should be supporting them, not the member/family ensuring that the system runs smoothly for the system itself. The multilayered effect and complexities of constant changing and the effect of the silo approach needs to be removed and more of a holistic, person centred, case managed approach.

There should be social workers, embedded psychologists at local levels with the flexibility to address the needs of who is requiring help and assistance, not this 'one size fits all' approach. That latter approach is the antithesis of the Mental Health Review and the recommendations from ACPMH and others. One does start to wonder (as does many people now) why this centralised one size fits all is still the approach, unless it is another example of ticking a box to relinquish true responsibility. As stated by a member: *"A quick power point and the drone of voices during a 2 day debrief on return and not continual catch up is inadequate. This is the one size fits all mentality".* Or by a partner: *"Death by power point and I am supposed to be resilient for when he gets home, do they really know what it is like?".* There needs to be more front line staff and less layers of bureaucracy.

We sincerely hope that this current Senate Enquiry does not result in more changes that merely turn the system and processes around but not remove the complexities and the inflexibility it has. We hope that this enquiry ensures that the outcomes are monitored and audited in terms of how many each department helps and in what ways. Audited and reviewed in such a way that the true outcomes are found and not what departments want to be found. Audited independently.

We thank you for the opportunity to submit this report to your Inquiry

Kind regards

Gail MacDonell

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Introduction

Who are we

We are a Foundation set up by current and past serving Australian Military Personnel and their Families.

We aim to provide funds for research that are not encumbered by political and/or Departmental outcomes.

AFOM aims to act as an aegis to:

- Provide a high standard of *integrity* and *ethics* in Research of Australian Military Families;
- Acknowledge people's contributions and intellectual property;
- Promote trust and confidence within the military and veterans as well as general community regarding research;
- Assist in coordinating and communicating current research primarily to integrate it into a cooperative and program approach.
- Moreover, to provide education and support to military and non-military communities on mental health and well-being issues, based on supported research, best practice and expertise in given areas.

Background to the submission

We have based our submission on the person centred and holistic approach – in line with the various national reports on mental health and in line with the mission statements, corporate governance etc. statements of the Departments concerned.

We have used peer-reviewed papers and Government reviews on the Mental Health Suicides and Family issues. We have also incorporated personal issues brought to us as well as ongoing issues that appear to be lingering.

Based on the background our assumptions are below.

Assumptions

We have put together this submission based on various assumptions, locally and globally. Firstly Defence,

The mission of the Australian Defence Force (ADF) is to defend Australia and its national interests.[1] To achieve this it should reflect the values and beliefs of the society for which it defends. The Australian Values Statement articulates these to be:

> *"respect for the equal worth, dignity and freedom of the individual, equality under the law, equality of men and women, equality of opportunity and peacefulness".*[2]

These fundamental values are also found in *The Universal Declaration of Human Rights* for which Australia is a signatory (United Nations, 1948).[3] The need for the ADF to defend the national interests should not override the Australian values it seeks to protect and the rights of those who make sacrifices for this service.

The Department of Veteran Affairs fully supports its statement of Corporate Governance:

> *"DVA is accountable to Government and citizens for effective delivery of its services and administration. In delivering the Department's programs and outcomes, the governance framework is built upon principles of accountability, leadership, executive instructions and quality control. These elements include the principles of care and compassion for clients in recognition of their service and sacrifice in the defence of the nation".*

More globally, the World Health Organisation (WHO) states:

> *"Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work*

[1] Department of Defence (2015). *About Defence.* **http://www.defence.gov.au/AboutUs.asp**

[2] Department of Immigration and Citizenship (2007). *Life in Australia.* **http://www.immi.gov.au/living-in-australia/values/book/english/lia_english_full.pdf**

[3] United Nations (1948). *The Universal Declaration of Human Rights.* **http://www.un.org/en/documents/udhr**

productively and fruitfully, and is able to make a contribution to her or his community".[4]

Moreover, that:

"Mental health is produced socially: the presence or absence of mental health is above all a social indicator and therefore requires social, as well as individual solutions. A focus on collective efficacy, as well as personal efficacy is required. A preoccupation with individual symptoms may lead to a 'disembodied psychology' which separates what goes on inside people's heads from social structure and context".[5]

Similarly, a multidimensional approach suggests that individual and environmental influences are inseparable from each other and form a system of interaction.[6] Individual experiences are not only influenced by inner biological, psychological and spiritual dimensions, but are also influenced by external dimensions - *relational* (partners, family, peers - the quality of these relationships and their impact on an individual), *social* (the interconnection/linkages between the different relationships), *cultural* (beliefs, norms and ideologies), structural (systems and policies). Intervention at any dimension will influence the others.[7]

In understanding and treating of mental health issues, an approach is needed that not only addresses the biological and psychological needs of an individual, but also acknowledges and addresses the broader relational, social, cultural and structural influences that have contributed to the development of mental health issues. A holistic and collaborative systems approach is needed to address the mental health issues of current and ex ADF members.

These issues did not develop in isolation; therefore, they should not be treated as such.

[4] World Health Organisation (2014). *Mental health: a state of well-being.* http://www.who.int/features/factfiles/mental_health/en

[5] Friedli, L. (2009). *Mental health, resilience and inequalities.* http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

[6] Harms, L. (2010). *Understanding human development: a multidimensional approach.* South Melbourne, Victoria Oxford University Press

[7] Ibid.

Terms of Reference Responses.

a) The extent and significance of mental ill-health and post-traumatic stress disorder (PTSD) among returned service personnel;

We concur and support the submission given by the VVF, with added attachments of peer reviewed research in this area. We believe that research done in this area, which does not provide for the Healthy Soldier Effect (HSE) does not reflect the true extent and significance of the issues.

Research has shown that exposure to combat is associated with an increased risk of developing Post Traumatic Stress Disorder (PTSD). Combat trauma has also shown to have negative impact in dyadic relationships[8] [9] [10] [11] [12]

Studies into more current dyadic relationships in younger and more educated couples where the veteran has PTSD, has continued to show similar results (Erbes, Polusny, MacDermid, & Compton, 2008; Renshaw & Caska, 2012; Renshaw, Rodrigues, & Jones, 2008), as previous war/conflicts (J. C Beckham, Lytle, & Feldman, 1996; J.C Beckham, Sampson, Feldman, Hertzberg, & Moore, 2002).

Dekel, Solomon, and Bleich (2005) explored the relative impact of the veterans' impairment along with the partners' distress related to partners' marital adjustment. They found that the partners' distress mediated the relationship between the veterans' level of impairment and the partners' marital adjustment. That is, veterans' level of impairment was related to greater distress in their partners, which in turn reduced well-being outcomes in partners (Dekel, Solomon, & Bleich, 2005).

Post-Traumatic Stress Disorder

Further, on the Health Soldier Effect, there needs to be longitudinal studies into defence mental health that include current serving and ex-service personnel. The sign and

[8] Arzi, Solomon, & Dekel, 2000
[9] Galvoski & Lyons, 2004;
[10] MacDonell, Marsh, Hine, & Bhullar, 2010
[11] MacDonell, Thorsteinsson, Bhullar, & Hine, 2014
[12] Monson, Taft, & Fredman, 2009

symptoms of Post-Traumatic Stress Disorder (PTSD) can develop soon after trauma or for some years after the event[13]. It is possible that due to the HSE, service personnel will not develop PTSD until sometime after the event and indeed may only become more prevalent upon separation from the ADF and the in-service support and peer shared experiences. Due to the ADF culture and the HSE, it is also possible that members will be able to continue to work relatively normal while starting to suffer the onset of PTSD. US research into military families found that veterans who experienced combat stress were more likely to have disrupted relationships with spouses and children[14].

The Review of Mental Health Care in the Australian Defence Force and Transition through Discharge also acknowledged that families are often the first to recognise change in members and should have a system to seek help for the member. [15] Therefore, we believe any research into veteran mental health must include families, as they are usually the first and best source of indicators of change in behaviour of personnel.

Mental ill health

So far, there has been a large focus upon suicide and PTSD in deployed personnel. However, like physical health, mental ill health ranges from temporary to permanent and small to severe in its effects. The 2010 ADF Mental Health and Wellbeing Study identified a statistically significant number of ADF personnel with depression, suicidal thoughts and anxiety compared to the normal population[16]. The ADF did not have a significant number of suicides and PTSD compared to the normal population. This may be because of support services available within the ADF and the HSE; it may also be that ADF members with severe mental health issues discharge from the services are therefore not recorded in the study. Regardless, the wellbeing study demonstrates a concerning number of low to middle range mental health issues within the forces. There remains anecdotal evidence that ADF

[13] National Institute of Mental Health (2013). *Post-Traumatic Stress Disorder* http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-easy-to-read/index.shtml

[14] MacDermid Wadsworth, S. M. & Southwell, K. (2011). Military Families: Extreme work and Extreme "work family", *ANNALS*, 638.

[15] Dunt, D. (2009). *Review of Mental Health Care in the ADF and transition through to discharge.* http://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/healthstudies/ReviewofMentalHealth1May2009.pdf

[16] McFarlane, A. C., Hodson, S. E., Van Hooff, M. & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report.* Department of Defence: Canberra.

members are reluctant to seek support for mental health issues. Deployment stress and trauma that does not result in obvious PTSD may still create depression, anxiety, mood/personality change and alcohol and drug use. Much of these mental health issues can be easily hidden from the work place and may only be noticed by friends and family. Again, as already mentioned we believe any research into veteran mental health must include families, as these are usually the first and best source of indicators of change in behaviour of personnel.

Professor Forbes in his submission to the Senate Enquiry in 2013 wrote that 54% of Australian Defence members will have a psychiatric disorder issues and that depression in the Defence Force was 6.4 per cent compared with 3.1 in the broader Australian community, and that the rate of PTSD in 2010 was 8.3 per cent compared with 5.2 in the general community. Professor McFarlane said that this means that the ADF has a much higher burden of mental illness than the general community does.[17]

Suicides and deaths

While some issues have been addressed, post the Dunt Review into Suicides[18]. – There does not appear to be an evaluation process that looks at the outcomes of those changes. In light of the Geffrey Gregg[19] and Gary McColley[20] suicides – Where recommendations to identify those at risk post Gregg's suicide were not taken up with the McColley case. How do we know what is happening without when there is formal way of record keeping?

Anecdotally we have been told that many in-service suicides are related to relationship issues and/or breakdown. Also over half the ADF suicides have been classified as not deployment related. So we need to find out what are the triggers for these suicides - the impact of military life on the family life? Further research is required on the impact of

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[17] http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=jfadt/wounded_injured/report/chapter5.htm

[18] Dunt, D. (2009). *Independent Study into Suicide in the Ex-Service Community.* http://www.dva.gov.au/sites/default/files/files/consultation%20and%20grants/healthstudies/Dunt%20Suicide%20Study%20Jan%202009.pdf

[19] Inspector General – Australian Defence Force (2007). *Inquiry Report Signaller Geffrey Phillip* Gregg. http://www.defence.gov.au/publications/igadfinquiryreportsignallergregg.pdf

[20] *Dodd, M. (2009). Vietnam vet killed himself after being let down by probe.* http://www.theaustralian.com.au/news/vietnam-vet-killed-himself-after-being-let-down-by-probe/story-e6frg6n6-1225742475757

deployment and defence life upon the relationships of defence members. The Dunt Review identified that families are paramount in the mental health of returned members. There exists no official relationship breakdown statistic from the ADF whether deployed or not. Data from the 2011 Defence Census indicated that 16.9% of permanent members have experienced divorce/relationship breakdown during their ADF service. As the median length of service is seven years, many ADF members may experience this breakdown within a short period.[21] We believe that it is vital that the ADF investigate the breakdown of marriage/relationship statistics within the ADF compared to the normal population.

Support for non-deployed members

The 2010 ADF Mental Health and Wellbeing Study found that over half of all suicides of current ADF members are those that have not deployed on operations. It also found that 22 per cent of the ADF population had experienced with a mental disorder in the previous 12 months with 39% of these personal not having deployed. It also identified that current non-deployed ADF members were just as likely to experience PTSD as those who had deployed.[22]

We need to find out what happening in the lives of current ADF members that is contributing to this. If this is occurring prior to deployment, then does this further increase the risk of more major mental health issues afterwards?

- Are the mental health needs of non-deployed ADF members and their families being met?
- What are the broader factors that may be contributing to the mental health issue of current ADF members?
- Anecdotal evidence suggests that relationship breakdown has been a contributor to these suicides. Are there characteristics of the military lifestyle that are contributing to this?

The Joint Health Command (JHC) Mental Health, Psychology and Rehabilitation Branch (MHPRB) have reported that the top presenting issues for its service was relationship

[21] Australian Human Rights Commission (2012). *Review into the treatment of Women in the Australian Defence Force.* **https://defencereview.humanrights.gov.au/sites/default/files/adf-complete.pdf**

[22] McFarlane, A. C., Hodson, S. E., Van Hooff, M. & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report.* Department of Defence: Canberra.

issues.[23] Given this, it is surprising that psychologists within this branch continue to work exclusively with the ADF member and have no sanctioned role in working with family members[24].

The Australian National Audit Office has suggested that DCO's step back from the direct provision of counselling and the referral to community services for non-veteran ADF members and their families might affect the timely provision of services to them from already overloaded community organisations.[25] Moreover, that when these community services are inadequate that other Defence services should be expanded to include other more Defence support services. As the JHC MHPRB report that relationships issues are the top presenting issue for their service, they would be suitable to provide this. DCO should expand their services or put more of the budget into local services.

Integration of programs

Energy should not only be invested in the development of programs but also the pathways between programs and services.[26]

The Broderick review suggested that there should be integration of the support provided to members and families.[27] The review heard:

> *"The programs that exist within Defence are still very much 'this is for the member, this is for the family'…they need to get those programmes connected and then, you know that would really show that a member is considered to be a part of the family unit. It's not an 'us and them' …mentality"*

[23] Australian National Audit Office (2013). Delivery of bereavement and family support services through the Defence Community Organisation. http://www.anao.gov.au/~/media/Files/Audit%20Reports/2012%202013/Audit%20Report%209/Report%20No9.pdf p. 125

[24] Siebler, P. N. (2009). Military people will not ask for help: experiences of deployment of Australian Defence Force personnel, their fam. (Doctor of Philosophy), Monash University, Victoria, Australia. http://arrow.monash.edu.au/vital/access/services/Download/monash:27012/THESIS01

[25] Australian National Audit Office (2013).

[26] MacDermid Wadsworth, S. M. (2014). Military Families in Transition in the Next Decade.

[27] Australian Human Rights Commission (2012). Review into the treatment of Women in the Australian Defence Force. https://defencereview.humanrights.gov.au/sites/default/files/adf-complete.pdf (p. 288).

Recommendations for a

(1) All future (and past) research take into account the Healthy Soldier Effect.

(2) That families (if requested by the member or family) be involved in mental health assessment and treatment of a member with a mental health problem.

(3) That the current Military Lifestyle be examined in a more exacting manner to account for Mental Issues (particularly concerning relationship issues). IF as suggested that 54% of Defence Members will experience a psychiatric condition, then this should be a priority – if they are keeping in line with mission statements.

(4) That a current and accurate suicide register be established and looked at concurrently with DVA and Department of Health records to more accurately gauge the suicide rate. Information gathered months or even years later is not good enough and it should not be left to outside organisations and people to try and get people to contact them in case someone suicides. This is a responsibility of the Departments.

(5) That all programs be reassessed and examined for a more family approach and better health and well-being approach for Defence members.

(6) Programs be re assessed to see if they concur or conflict with each other.

b) Identification and disclosure policies of the ADF in relation to mental ill-health and PTSD;

Screening

ADF members go through an extensive recruitment process that includes psychological screening that includes an interview and psychological report from a defence psychologist. The ADF has recently ruled out annual mental health screening and current Individual Readiness requirements (IR) for general service only require a five yearly medical review. Deployed members are screened via self-report assessment instruments and interviews. There remain significant gaps in this process that we find worrying.

Firstly, we have spoken to current serving members who stated that they failed to receive a 'recommended' from their recruitment psychology interview. Currently, only the medical and/or recruitment officer can give a not suitable to an applicant, not the Defence psychologist. [28] Indeed, as defence recruiting is largely run by a private company paid to recruit set numbers, the recruiting officer can choose to ignore a not-suitable recommendation from the Psychologist to fulfil recruiting number requirements. We find this possibility very concerning, as once a person is recruited into the ADF it becomes difficult for the ADF to discharge unsuitable members and there is the likelihood that personnel that have been identified as at risk to psychological problems before recruitment could be further exposed to trauma and/or mental health problems through defence life and deployments.

Secondly, annual screening have been ruled out and medical reviews if members are healthy only occur once every 5 years. As the average defence career is less than 10 years, this seems a long time between checks. Instead, the ADF has decided to tackle mental health by empowering members to assess their own mental health. While information and cultural change is important, we ask whether it is wise to rely solely on a strategy that needs members that have traditionally been reluctant to report to suddenly start self-reporting.

Thirdly, The Dunt Review identified a need to increase the skills and numbers of mental health workers within the ADF. While defence stated they had increased the mental health

[28] Campbell, L. & Smith, A. (n.d.) *Enlistment Procedures And Initial Training Program: Kapooka Army Base* http://www.aic.gov.au/media_library/publications/proceedings/13/campbell.pdf

workforce, there is no evidence that the military uniformed psychology corps has increased. From the previous Senate Submission experts from Australian Centre for Posttraumatic Mental Health (now known as the Phoenix Australia) advised that embedded Psychologists be on deployment.[29] We state that given the data, supplied by Defence that embedded Psychologists should be throughout all the services particularly on base.

1. Are there if not why not, plans to implement full time uniformed psychologists across all three of the forces? Only the Army trains and utilises full time uniformed psychology officers. Surely uniformed psychologists would have greater insight into military culture and unique challenges that members face than non-uniformed psychologists would. In addition, deployed uniformed psychologists are best placed to understand deployment related mental health issues.

We are aware that the ADF is in a constant state of review for post deployment screening practices. However, are there currently any plans to include members of the deployed people's family into the process? As already stated, the family is the mostly to be the first to identify issues.

We are aware that there is currently an opt-out option for ADF members concerning the privacy act for reasons of disclosure. We ask how this option is being communicated to ADF members and is this option offered to all new ADF members upon joining. Lastly, is there, are there plans to change the privacy act and defence policy in the future to allow for better communication to immediate family in regards to mental health issue?

Recommendations for b

(1) That routine 12 monthly screening be done for all Defence Personnel.

(2) That Family be involved (where possible) within the screening process.

[29] Inquiry into the Care of ADF Personnel Wounded and Injured on Operations (Chapter 5) http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=jfadt/wounded_injured/report/chapter5.htm

(3) That Embedded Psychologist be trained and employed as a **matter of urgency** – given that statements of 54% of personnel will have a psychiatric problem and that 50% of the suicides in Defence currently are of non-deployed personnel.

(4) That an urgent review of the procedure and follow through of post deployment assessment occur. One that involves correct assessments and not tick boxes.

c) Recordkeeping for mental ill-health and PTSD, including hospitalisations and deaths;

Silos

Recording keeping should have a more consolidating pattern that benefits the service personnel (while taking into account privacy issues). The 'silo' approach and privacy issues appears to be having a more detrimental effect on those that require support and assistance.

Dr Andrew Southcott is quoted as saying:

> *"The Australian health care system can ultimately be characterised by a lack of integration, with our health care system having been described before as "a series of disjointed silos and structural relationships". The interface between primary health care and acute hospitals is an area which could be improved, and generally suffers from a lack of information sharing, and communication"* [30]

If that is occurring within one system/department (Health), then one can only ponder the amount and strengths of Silos between multiple departments. This can lead to excessive visits to Medical Officers (MO's); multiple non-warranted medical and psychological testing; loss of time waiting for conveyancing of reports and even lost reports between the systems. Simultaneously, more budgetary (taxpayers) money is wasted and most importantly, and more stress is created on the personnel and their family.

Anecdotally, these problems come up repeatedly with current serving and in particular ex-serving personnel and those going through transition. Brigadier Bill Rolphe (Retd) spoke about the need to dismantle Silos within Defence/DVA and other relevant departments in a previous Think Tank in Canberra[31].

[30] Southcott, A. (2011). *Diagnosing Australia's Health Care System.* http://australianpolity.com/australian-polity/diagnosing-australia%E2%80%99s-health-care-system

[31] Centre for Military and Veterans' Health (2010). *Think Tank Report 2010.* http://www.camvh.org.au/ThinkTank/CMVH2010ThinkTankReport.pdf

Recommendations for c

(1) That Defence and DVA urgently look at decreasing the multiplicity and duplicity of assessments required. That the member is put first in this deliberation. For example, establish flow charts of the processes that look at the ease for the member and not the departments need to have a box ticked before they go any further.

(2) That the relinquishing of responsibility/accountability from one to department to another ceases and that a database/way of record keeping be established that cover during and after service- members can have their health records on a continuum. The current system is not good enough and members and their families deserve so much more. If the member is NOT connected fully to DVA on leaving the service, another system of follow through should occur.

d) Mental health evaluation and counselling services available to returned service personnel;

Evaluation

All ADF personnel receive pre-deployment briefs designed to enhance ability to operate in a deployment environment. Personnel are not evaluated for psychological health before deployment, this is assumed and the well-being of the member is the member's responsibility. However, deployment allowance and tax benefits are a big financial incentive for ADF members. [32] Therefore, personnel with existing issues may be enticed by the financial gain, making the existing issue worse in the process.

General personnel are only required to complete a five yearly medical and no psychology reviews. Unless commanders are aware of existing issues of personnel, there exists no screening to prevent personnel from volunteering for deployment. Without regular psychological assessment, the next best option is to provide as much information and support to members families to avoid members deploying with possible existing psychological and family issues that could be exasperated by a deployment.

At the end of a deployment, personnel are required to undertake the Return to Australia Psychological Screen (RtAPS). This comprises a questionnaire and screening interview. The screening interview is conducted by Army Psychology Corps members. While the RtAPS is designed to bring up so-called "red flags" for traumatic exposure, it still mostly relies on self-report.

There is a heavy reliance on the low number of skilled and experienced uniformed psychologists to assess individuals. Psychologists are commissioned officers in the Army with authority to make psychological assessment and recommendations on individuals. Ultimately, decisions are often still left to individuals and their commanders. It is not enough to increase the mental health workforce at home in Australia without also looking at ways to increase uniformed staff skilled and experienced and with enough authority to assess individuals overseas on deployment.

[32] Department of Defence (2011). *DI (G) PERS 16–28 Operational mental health screening.* https://www.navy.gov.au/reserves/sites/default/files/DI%28G%29%20Pers%2016-28%20%20Operational%20mental%20health%20screening.pdf

Post deployment, between 3 to 6 months after the deployment members complete the Post Operational Psychological Screen (POPS). Again, the POPS comprises a screening questionnaire and interview. Nowhere within this process is there a requirement to engage the member's peers, commanders or their families. Again, the process relies heavily on self-report and the assessment ability of the Psychology staff. We believe that there should at least be an option for family members to complete a questionnaire, as already stated research shows it is often the family that are first to notice behavioural change and are usually the ones who are left to deal with many of the problems.

Regimental Aid Posts

From personnel working with current serving members: A reliable source (who does not wish to be named for fear of repercussions – that in itself should ring alarm bells).

> *"As you would be aware there has just been another suicide in the Williamtown area.* [33]
>
> *Yet nothing much seems to be happening on the positive side of the things, particularly with the privatisation of the RAPs (Regimental Aid Posts).*
>
> *For non-urgent appointments there is up 3-4 weeks wait.*
>
> *Since Williamtown is mainly staffed by civilian employees there has been nearly a 2/3 turnover of staff within 2 years*
>
> *Roughly, with three practice managers within that same two years.*
>
> *Rehab coordinators have a turnover of roughly the same (as this is also on a contract basis)*
>
> *There are only currently two part time Military doctors*
>
> *Triage is done in the main foyer – behind a screen in front of reception.*
>
> *Trying to get a continuous care model is practically impossible*
>
> *Attempting claims is made so much harder as you cannot always be guaranteed of the same doctor who is working through the paper work for you"*

Ongoing work around prejudice and stigma needs to be done. This needs to be done at all levels. There has been much written about this in all reports and reviews and does not need to be rewritten here. – See Recommendation 3. Below.

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[33] http://www.abc.net.au/news/2015-03-04/defence-officials-urged-to-act-after-another-suicide-involving-/6278746

Recommendations for d

(1) That family be involved in post deployment assessment (where applicable). Even if there are only adjustment issues, these could be attended to by the embedded psychologist/s and the member and family could be helped before an escalation occurred. The positives of this could be:

- It could be viewed of more of a shared problem rather than just a member problem
- it could deescalate any current major issues
- it could prevent the development/increase in mental health/psychiatric problems
- it could increase resilience and growth as a family unit

(2) That a document that shows the possible pathways to care post deployment be produced to help allow members know that care is available and the possible scenarios that are available for them.

(3) That any mental health or psychiatric disorder post deployment be designated under an umbrella term of "Operational Service Disorder". Specific medical/mental health feed into the stigma. Terms such as "Operational Service Disorder" imply more of something that has occurred because of operational service and not as a weakness on the member's part.

f) The support available for partners, carers and families of returned service personnel who experience mental ill-health and PTSD;

Partners of veterans with PTSD are often highly distressed and receive limited support to address these issues.[34] Higher levels of chronic stress and poor mental health and wellbeing has been identified in female partners of Vietnam veterans. This has been attributed to the living with and meeting the care needs of the husbands[35]. Research suggests that looking after partners and families results in better outcomes for the veteran[36].

The support given to partners, carers and families stated in is varied and depends on different factors:

1. The location of the member/family
2. The amount of family close by
3. The amount of services close by
4. If they are current or past serving
5. The degree of ill health of the member
6. The coping skills of the family/carer/partner
7. The degree of mental health changes from pre-deployment to post deployment
8. The stage of the relationship between the member and the partner/carer/family

Again: One size does NOT fit all

The 2011 Defence Census stated that 56% of permanent ADF members had been deployed since the on operations since January 1, 1999.[37] ADF members who are veterans and their

[34] Manguno-Mire, G., Sautter, F. P., Lyons, J. P., Myers, L. P., Perry, D. M., Sherman, M., Sullivan, G. (2007). Psychological distress and burden among female partners of combat veterans With PTSD. *The Journal of Nervous and Mental Disease.195* (2), 144-151.

[35] Outram, S. Hansen, V., MacDonell, G., Cockburn, J., Adams, J. (2009). Still living in a war zone: perceived health and wellbeing of partners of Vietnam veterans attending partners' support groups in New South Wales, Australia. *Australian Psychologist, 44*, 128-135.

[36] Taft, C. T., Schumm, J. A., Panuzio, J., & Proctor, S. P. (2008). An examination of family adjustment among operation desert storm veterans. *Journal of Consulting and Clinical Psychology, 76*(4), 648-656. doi: http://dx.doi.org/10.1037/a0012576

[37] Department of Defence (2012). Census 2011 Public Report.

families are entitled to free counselling (including relationship counselling) through the Veterans and Veterans Families Counselling Service (VVCS).[38]

Children of Defence Families

From the partners/spouses of current serving members:

> *"We need counselling/psych services for children under 5. We are told that children under six cannot be diagnosed with PTSD. We are not saying they have PTSD"*

While diagnosing PTSD in children under six is difficult, behavioural issues can certainly occur while living with someone with PTSD. A small child living with someone with PTSD can have a huge effect on their environment, attachments, memory and cognition. In addition, PTSD can occur in preverbal years.[39] Therapies that may help can be in way of – play, behavioural techniques, psychoeducational and family support.

To say that they VVCS cannot help and cannot diagnose children with PTSD is incorrect. Having an infant/child who is experiencing behavioural issues should (as good practice would dictate) a priority of care in a family where PTSD/mental health/readjustment issues were present.

Defence Community Organisation

The Defence Community Organisation (DCO) was established in 1986 as the key service delivery agency within Defence "to assist Command to meet its responsibilities and obligations to Defence members and their families through the delivery of targeted services and programs accompanied by policy and management advice".[40] It aims to support members and families to balance the demands of military service with their personal and

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[38] Veterans and Veterans Families Counselling Service (n.d.). *About Us.* http://www.vvcs.gov.au/documents/vvcs-overview.pdf

[39] Blank, M. (2007). Posttraumatic stress disorder in infants, toddlers, and preschoolers, Issue: BCMJ, Vol. 49, No. 3, April 2007, page(s) 133-138

[40] Australian National Audit Office (2013). Delivery of bereavement and family support services through the Defence Community Organisation. http://www.anao.gov.au/~/media/Files/Audit%20Reports/2012%202013/Audit%20Report%209/Report%20No9.pdf

family commitments. Fifty eight percent of Permanent Force members are in independent relationships (married or defacto).[41]

In 2012, the Australian National Audit Office (ANAO) conducted an audit into the Delivery of bereavement and family support services through the Defence Community Organisation.[42] It found that historically, families of current service personnel were provided with ongoing counselling by social workers employed by the Defence Community Organisation. However, this role has now been reduced to a brief intervention and a referral approach where families are referred to services in the community. It has been identified that these services are already overloaded and are reluctant to take on the referrals.[43] DCO operate a 24 hour hotline intake service which is stated is staffed by trained social workers and psychologists. However, it was identified that only 50% of the hotline workers have these required qualifications[44].

For those still in Defence – Defence Community Organisation is stated (by Defence) to be the organisation to turn to. Anecdotally, where the member and family are located determines the amount of support that is given in times of need.

With a DCO budget of $38.5 Million per year, along with a Defence/DVA program budget of $192.3 Million - it is sad to say many have been left to flounder with their (family/carer/partner) issues. Once again, the responsibility appears to left to "another section" and not enough follow up is done. Many local areas are left with part time "Family Liaison" people from DCO, who have NO flexibility to address needs, merely refer people to other services, which may or may not be available for the Partner/Carer/Family.

Waiting times for Dr's on many Medical Bases are long in the extreme and cumbersome in that MO's change all the time for the member, and there is no continuity of care.

This is the antithesis of the recommendations of the Report of the National Review of Mental Health Programs (2014) and Recommendations from the 2010 ADF Mental Health Prevalence and Wellbeing Study.

[41] Department of Defence (2012). Census 2011 Public Report. p. 11
[42] ANAO (2013)
[43] Ibid.
[44] Ibid.

The 2010 ADF Mental Health Prevalence and Wellbeing Study recommended:

> ***Goal 1 – Enhancing the mental health workforce***.
>
> *Over the four years of the reform process, $84 million has been allocated to enhance the mental health workforce at the local, regional, national and strategic levels. The reform process has increased the mental health workforce by 25% and aims for an increase of more than 50% by mid-2013.*
>
> *Priorities for expansion include:*
>
> a. ***local/regional service delivery:*** *the creation of multidisciplinary teams to deliver mental health and occupational psychology services, as well as implement prevention initiatives*
> b. ***National:*** *an ADF Centre for Mental Health staff to provide a mentoring, supervision and training resource with National Coverage.*

Again, anecdotally, there appears to be a pull away from the regional areas, and more resources put into National Systems that do not necessarily flow down to the member.

To achieve the required system reform, the Commission recommends changes to improve the longer-term sustainability of the mental health system based on three key components:

1. Person-centred design principles
2. A new system architecture
3. Shifting funding to more efficient and effective 'upstream' services and supports.

Recommendations for f

(1) We fully support the recommendations of the Review into *National Review of Mental Health Programs – as below to apply to DCO and Defence/DVA funding programs.*

(2) To expand VVCS services – to encompass children of all ages, for either assessment and therapy or referral. Early detection and prevention is the key to help prevent future problems and issues. This may be particularly helpful during times of deployment, adjustment issues upon return and/ or while addressing other health problems of the member.

If the Department/Government are serious about this situation –

(3) We recommend that qualified Social Workers (who were not on short term contracts) to be located in all the military areas – including and in particular regional area. That these Social Workers are given the flexibility and resources to implement, run and adjust programs or services for Defence Families, in their area. Remembering that one size does not fit all.

(4) If no other funding can be created then current funding be shifted to upstream services (coalface) and the levels of bureaucracy within DCO be dismantled to accommodate for the front line services.

We do not want to see another "review" of DCO. There has been enough "reviews"- This is time for action.

j) Any other related matters.

Research

Recommendation 9 of Defence Sub-Committee into the *'Care of ADF Personnel Wounded and Injured on Operations'* recommended that:

> *"The departments of Defence and Veterans' Affairs undertake a study into psychological support of partners and families of Australian Defence Force (ADF) members and ex-ADF members. The Committee further recommends that the study be conducted with the objective of developing recommendations to overcome partners' and families' mental health issues that may be highlighted by the study"* [45]

However, this recommendation was not supported by the Government, whose response was:

> *"The departments of Defence and Veterans' Affairs are working collaboratively on a strategic framework to facilitate and prioritise research programs, with families as one of the initial four research domains for the Department of Veterans' Affairs (DVA). However, the recommendation of a specific study into the psychological support of partners and families of ADF members and ex-ADF members is not supported.*
>
> *The departments of Defence and Veterans' Affairs have numerous programs and services in support of partners and families of ADF and ex-ADF members that have been developed from existing available research and evidence base in recognition of their psychological and social needs".*

Surely, the fact that this recommendation was made by the committee carries an assumption that it found that the existing data and research regarding partners of current and ex ADF members was insufficient.

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45 http://www.aph.gov.au/parliamentary_business/committees/house_of_representatives_committees?url=jfadt/wounded_injured/report/prelims.htm

Although the Departments have numerous programs:

- What is the evidence base for these programs?
- The credibility/relevance of this evidence base?
- What evaluations have been made to determine the effectiveness of these programs?
- What outcomes are they measuring?
- Are these evaluations publically available?

If Defence are prepared to change/adapt current mental health policy/programs for members, they also need to re-evaluate and adjust policy/programs for partners/families accordingly. To achieve this, current programs should be re-evaluated and the results of this re-evaluation should be publically released for transparency.

Defence Social worker Philip Siebler states:

> *"The bulk of literature past and present has had a focus on military concerns alone – that is, the operations of war and peacekeeping to the exclusion of family life"*[46]

There is currently an absence of publically available Defence and/or academic research that focuses primarily on experiences of the Australian military family. Due to this lack of Australian family research, knowledge is taken from international research, which has extensively investigated not only deployment, mental health, PTSD; but also the impact of the military lifestyle on families, etc.

Australian studies have primarily focused on the impact of the deployment of an ADF member on their family.[47] [48] Research that has sought the views of partners directly have been conducted are primarily large-scale mailed out/online surveys with no peer-reviewed

[46] Siebler (2009) p. 100
[47] Ibid
[48] Runge, C. E., Waller, M., MacKenzie, A., & McGuire, A. C. L. (2014). Spouses of Military Members' Experiences and Insights: Qualitative Analysis of Responses to an Open-Ended Question in a Survey of Health and Wellbeing. PLOS One, 9(12).

publication of their findings, with lower responses rates to that of the 2011 Defence Census.[49] [50]

Although, quantitative research such as this can be easier to administer and analyse, however it can fail to capture the lived experiences of the participants. Qualitative research on the other hand provides:

> *"A sense of what it's like to walk in the shoes of the people being described – providing rich details about their environments, interactions, meanings, and everyday lives"*[51]

Although the Australian Institute of Family Studies is currently conducting a Family Wellbeing Study on behalf of the department of Defence, this study is also another quantitative survey. Siebler states that the term 'survey fatigue' has been used in the Australian context[52].

The Hamilton report first highlighted the impact of the military lifestyle on partners and families. A report on the *Main Problems Facing Spouses of Australian Defence Force Personnel and Some Recommended Solutions* was released in 1986.[53] The study methodology consisted of extensive consultations with partners of service personnel and written submissions. The author travelled to both large and small military bases to achieve this. Also within a Defence context, a similar approach was utilised in the *Review into the treatment of Women in the Australian Defence Force (The Broderick Review)* by the Australian Human Rights Commission.[54] This review utilised by quantitative and qualitative methods to explore the terms of reference of the review.

The Hamilton report was first released almost 30 years ago. Yet the issues identified within this report still exist and there has not been a similar study that has explored these issues as in depth as this study.

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[49] Atkins S. (2009). A picture of Australian Defence Force Families 2009 - Results from the first survey of Australian Defence Force Families. Canberra: Directorate of Strategic Personnel Policy Research.
[50] Defence Families of Australia (2014). *Annual Family Survey 2014* Report **http://www.dfa.org.au/sites/default/files/DFA%20Annual%20Family%20Survey%202014%20Report.pdf**
[51] Rubin, A. and Babbie, E. (2005). *Research methods for social work.* Belmont, CA: Brooks/Cole. p. 155
[52] Siebler (2009) p. 6
[53] Hamilton, S. (1986). Main Problems Facing Spouses of Australian Defence Force Personnel and Some Recommended Solutions **http://www.defence.gov.au/dco/documents/Hamilton%20review.PDF**
[54] Australian Human Rights Commission (2012). *Review into the treatment of Women in the Australian Defence Force.* **https://defencereview.humanrights.gov.au/sites/default/files/adf-complete.pdf**

Partner Employment

One of the issues explored in the Hamilton study was the impact of relocation on partner employment. Recently the 2011 Defence Census identified that fifty-nine percent of ADF partners had changed jobs due to service related relocation with the average number of job changes due to relocation being 3.3. Following the last relocation, the average period of unemployment was 5.4 months. Fifty-two percent of partners were earning less in their new jobs than their previous employment. Eleven per cent were unemployed; this is compared to the national average of 5% (Australian Bureau of Statistics, 2012).

International peer reviewed research has found that partners of military members are less likely to be employed and earn less when they do.[55] [56] Quantitative studies have found that higher levels geographic mobility are associated with negative employment outcomes and loss of annual earnings for partners of military personnel. Partners with geographic stability are more likely to be employed. [57] Relocation is associated with a decreased likelihood of employment, loss of income and a drop in hours worked per week.[58] Relocated partners can experience loss of familiar environments, valued relationships, employment and self-esteem and that these losses elicit mourning responses. It argued that military culture discourages partners from seeking emotional support for this distress and that repeated unattended loss undermines one's entire identity. [59] In one study, two-thirds of respondents felt that their spouse's military career had influenced them negatively and one-third felt that this was due to frequent and disruptive moves.[60]

Two small Australian studies have investigate employment and experiences of wellbeing. Trewick and Muller found that employed spouses had higher levels of wellbeing and quality

[55] Dunn, J., Urban, S., & Wang, Z. (2011). Spousal Employment Income of Canadian Forces Personnel: A Comparison of Civilian Spouses. European Journal of Military Studies, 2(1).
[56] Lim, N., Golinelli, D., & Cho, M. (2007). *"Working Around the Military" Revisited.* http://www.rand.org/pubs/monographs/MG566.html
[57] Cooney, R., De Angelis, K., & Wechsler Segal, M. (2011). Moving with the Military: Race, Class and Gender Differences in the Employment Consequences of Tied Migration. *Race, Gender & Class, 18*(1-2), 360-384
[58] Cooke, T. J., & Speirs, K. (2005). Migration and Employment among the Civilian Spouse of Military Personnel. *Social Science Quarterly, 86*(2), 343-355.
[59] Jervis, S. (2009). *Military Wives and Relocation: A Psychosocial Perspective*. (Doctor of Philosophy), University of the West of England, Bristol.
[60] Castaneda, L. W., & Harrell, M. C. (2008). Military Spouse Employment: A Grounded Theory Approach to Experiences and Perceptions. *Armed Forces & Society, 34*(3), 389-412.

of life compared to unemployed spouses.[61] Runge and colleagues found that respondents in their study expressed frustration of having to find new jobs, at lower levels and sacrifice their own career ambitions. [62]

Defence policy response

The Defence Community Organisation recognises that "relocation can cause disruption to the ongoing employment of the partners of ADF members" [63] However, the program to address this issue, the Partner Education and Employment Program (PEEP) is an allowance, which covers:

a. professional employment assistance, such as career advice and job search skills; or
b. education and training courses (up to and including first time undergraduate degrees);
c. personalised résumé preparation;
d. professional re-registration costs under State legislative requirements payable on relocation;
e. superannuation set-up courses

This represents the issue as a 'skills' problem and assumes that the partner does not already have the skills and qualifications to secure employment in the new location and fails to recognise the negative impact that posting relocation and geographic instability has on partner employment.

Relocation

Defence members are relocated to positions in "order to satisfy capability requirements, for reasons of career development and for personal preferences"[64] Current policy aims to have

[61] Trewick, N. and J. Muller (2014). Unemployment in military spouses: An examination of the latent and manifest benefits, quality of life, and psychological wellbeing. *Australian Journal of Career Development 23(*2): 47-56.
[62] Runge, C. E., Waller, M., MacKenzie, A., & McGuire, A. C. L. (2014). Spouses of Military Members' Experiences and Insights: Qualitative Analysis of Responses to an Open-Ended Question in a Survey of Health and Wellbeing. *PLOS One, 9*(12).
[63] Defence Community Organisation (2014). *Partner Education & Employment Program (PEEP) Guidelines* **http://www.defence.gov.au/dco/documents/Resources/141001 - PEEP Guidelines 2014-15.pdf**
[64] Australian Human Rights Commission (2012). p. 140

postings of a minimum of three years. Relocations are decided upon by ADF career management personnel who meet or consult with the Defence member regarding their family circumstances. Partners are not directly involved in this process unless they are also an ADF member. [65]

The Broderick Review found that less than half of the ADF members (both male and female) they surveyed felt that their family circumstances were considered by their career manager.[66] This is further supported by the 2008 Defence Attitude Survey which found that 40% of respondent did not feel that they had adequate contact with their career manager.[67] Recommendation 17 of the Broderick Review identified the need for longer term career planning and recommended a whole of Defence 'Support for posting plan' form to be integrated into the career management process. With this plan being developed in *consultation* and with the *agreement* of the member. This recommendation sought to "provide ADF members with the opportunity to raise important issue that affect posting decisions". [68]

The Audit of this recommendation found that the introduction of this form was not supported by the Services who felt that the modification of existing forms was sufficient. This was of concern as the initial ADF review had "called for innovative rethinking of accepted models of work, allocation of duties, workforce management systems and supports to posting"[69]

In contrast, the United Kingdom, are currently introducing a 'New Employment Model' for service personnel which seeks to "better balance the demands placed on our people and their families". From its Armed Forces Continuous Attitude Survey, it recognised that domestic stability and partner employment were the key issues that influenced the member to leave the service.[70] The policy was developed as it was felt that

[65] Ibid.
[66] Ibid.
[67] Department of Defence (2009). 2008 Defence Attitude Survey - Summary of Results. http://www.defence.gov.au/dpe/dpe_site/publications/2008_Defence_Attitude_Survey_Summary_of_Results.pdf
[68] Australian Human Rights, Commission (2014). Review into the Treatment of Women in the Australian Defence Force - Audit Report. https://www.humanrights.gov.au/sites/default/files/document/publication/adf-audit-2014.pdf
[69] Ibid, p. 155.
[70] Ministry of Defence (2014). Armed forces continuous attitude survey: 2014. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/312289/afcas_2014_main_report.pdf

"the current package had become outdated and had not kept pace with the way in which people choose to live in the 21st century".[71] This policy is an important recognition that geographic stability is required for good outcomes for partner employment. It also provides choice on lifestyle that the family want to lead, based on needs and aspirations of all family members. It demonstrates that Service wide innovative change on posting and career management policy is possible.

ADF Family Support policy

Current ADF family support policy is articulated in the *Defence Family Support Manual.* Introduced in 2012, it replaced existing policy and Defence instructions regarding the provision of family support from DCO.[72] Within the manual, it is stated that:

> *"The Defence member bears primary responsibility for their own wellbeing and the wellbeing of their family".*[73]

The ANAO Audit identified that this conflicts with previous ADF Family Support Policy (DI (G) PERS 42-1) and the instructions of the Committee of Service Chiefs, which stated that:

> *"The wellbeing of Service families is integral to the efficacy and effectiveness of the ADF and is a shared responsibility between the ADF and member".*[74]

In contrast to the wording of the previous policy, the current policy could be considered an antithesis to the support needed by ADF members concerning their own mental health and that of their family. It is also conflicts with the ADF Family Covenant[75]

Recommendations for j

(1) To instigate Independent Research into the effects (both positive and negative) of Australian Military life on Families, with a peer reviewed articles from that research

(2) This research should encompass both quantitative and qualitative methodology.

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[71] Ministry of Defence (2014). The New Employment Model. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/345610/NEM_Phase_1_Report_Final.pdf

[72] ANAO (2013). P. 33

[73] Ibid.

[74] Ibid.

[75] Defence Community Organisation (n.d.) About *Us.* http://www.defence.gov.au/dco/Top

(3) A new Hamilton style review should be undertaken. This was identified as an action item at the 2012 Defence Family Forum.[76]

(4) To correct wording of the DCO manual (and also in practice) to fit with the ADF Family Covenant and Committee of Service Chiefs

(5) To re-evaluate the PEEP programme in quantity, size and scope.

(6) Determine the reasons behind constant relocations and balance them with the needs of the member with the requirements of the family. To also incorporate the needs of partners in gaining and maintain a career pathway.

[76] Defence Community Organisation. *Defence Family Forum – Open Space Agenda.* Itemshttp://www.defence.gov.au/dco/documents/Defence_Family_Forum_Action_Items.pdf

Recommendations summary

Recommendations for a

(1) All future (and past) research take into account the Healthy Solider Effect

(2) That families (where possible) be involved in mental health assessment and treatment of a member with a mental health problem

(3) That the current Military Lifestyle be examined in a more exacting manner to account for Mental Issues (particularly concerning Relationship issues). IF as suggested that 54% of Defence Members will experience a psychiatric condition, then this should be a priority – if they are keeping in line with their Mission Statement.

(4) That a current and accurate suicide register be established and looked at concurrently with DVA and Department of Health records to more accurately gauge the suicide rate. Information gathered months or even years later is not good enough and it should not be left to outside organisations and people to try and get people to contact them in case someone suicides. This is a responsibility of the Departments.

(5) That all programs be reassessed and examined for a more family approach and better health and well-being approach for Defence members.

(6) Programs be re assessed to see if they concur or conflict with each other.

Recommendations for b

(1) That routine 12 monthly screening be done for all Defence Personnel

(2) That Family be involved (where possible) with the screening process

(3) That Embedded Psychologist be trained and employed as a **matter of urgency** – given that statements of 54% of personnel will have a psychiatric problem and that 50% of the suicides in Defence currently are of non-deployed personnel

(4) That an urgent review of the procedure and follow through of post deployment assessment occur. One that involves correct assessments and not tick boxes.

Recommendations for c

(1) That Defence and DVA urgently look at decreasing the multiplicity and duplicity of assessments required. That the member is put first in this deliberation. For example, establish flow charts of the processes that look at the ease for the member and not the departments need to have a box ticked before they go any further.

(2) That the relinquishing of responsibility/accountability from one to department to another ceases and that a database/way of record keeping be established that cover during and after service- members can have their health records on a continuum. The current system is not good enough and members and their families deserve so much more. If the member is NOT connected fully to DVA on leaving the service, another system of follow through should occur. This above also be addressed to Term of Reference H.

Recommendations for d

(1) That family be involved in post deployment assessment (where applicable). Even if there are only adjustment issues, these could be attended to by the embedded psychologist/s and the member and family could be helped before an escalation occurred. The positives of this could be:

- it could be viewed of more of a shared problem rather than just a member problem
- it could deescalate any current major issues
- it could prevent the development/increase in mental health/psychiatric problems
- it could increase resilience and growth as a family unit

(2) That a document that shows the possible pathways to care post deployment be produced to help allow members know that care is available and the possible scenarios that are available for them.

(3) That any mental health or psychiatric disorder post deployment be designated under an umbrella term of “Operational Service Disorder”. Specific medical/mental health feed into the stigma. Terms such as “Operational Service Disorder” imply more of something that has occurred because of operational service and not as a weakness on the member’s part.

Recommendations for f

(1) We fully support the recommendations of the *National Review of Mental Health Programs – as below to apply to DCO and Defence/DVA funding programs.*

(2) To expand VVCS services – to encompass children of all ages, for either assessment and therapy or referral. Early detection and prevention is the key to help prevent future problems and issues. This may be particularly helpful during times of deployment, adjustment issues upon return and/ or while addressing other health problems of the member.

If the Department/Government are serious about this situation –

(3) We recommend that qualified Social Workers (who were not on short term contracts) to be located in all the military areas – including and in particular regional area. That these Social Workers are given the flexibility and resources to implement, run and adjust programs or services for Defence Families, in their area. Remembering that one size does not fit all.

(4) If no other funding can be created then current funding be shifted to upstream services (coalface) and the levels of bureaucracy within DCO be dismantled to accommodate for the front line services.

Recommendations for j

(1) To instigate independent research into the effects (both positive and negative) of Australian Military life on Families, with a peer reviewed articles from that report.

(2) This research should encompass both quantitative and qualitative methodology.

(3) A new Hamilton style review should be undertaken. This was identified as an action item at the 2012 Defence Family Forum.[77]

(4) To correct wording of the DCO manual (and also in practice) to fit with the ADF Family Support statement and Committee of Service Chiefs

(5) To immediately, increase the PEEP programme in quantity, size and scope.

[77] Defence Community Organisation. *Defence Family Forum – Open Space Agenda.* Itemshttp://www.defence.gov.au/dco/documents/Defence_Family_Forum_Action_Items.pdf

(6) Determine the reasons behind constant relocations and balance them with the needs of the member with the requirements of the family. To also incorporate the needs of the spouse in gaining and maintain a career pathway.