COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

FOREIGN AFFAIRS, DEFENCE AND TRADE REFERENCES COMMITTEE

Mental health of returned Australian Defence Force personnel

(Public)

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SENATE

FOREIGN AFFAIRS, DEFENCE AND TRADE REFERENCES COMMITTEE

Monday, 31 August 2015

Members in attendance: Senators Fawcett, Gallacher, Lambie, Whish-Wilson, Xenophon.

Terms of Reference for the Inquiry:

To inquire into and report on:

The mental health of Australian Defence Force (ADF) personnel who have returned from combat, peacekeeping or other deployment, with particular reference to:

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

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

c. recordkeeping for mental ill-health and PTSD, including hospitalisations and deaths;

d. mental health evaluation and counselling services available to returned service personnel;

e. the adequacy of mental health support services, including housing support services, provided by the Department of Veterans' Affairs (DVA);

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

g. the growing number of returned service personnel experiencing homelessness due to mental ill-health, PTSD and other issues related to their service;

h. the effectiveness of the Memorandum of Understanding between the ADF and DVA for the Cooperative Delivery of Care;

i. the effectiveness of training and education offerings to returned service personnel upon their discharge from the ADF; and

j. any other related matters.

WITNESSES

DOOLAN, Rear Admiral Kenneth (Retired), National President, Returned Services League of Australia

HODGES, Commander John (Retired), National Veterans' Affairs Adviser, Returned Services League of Australia

Committee met at 09:00

CHAIR (Senator Gallacher): I declare open this public hearing of the Senate Foreign Affairs, Defence and Trade references committee. This public hearing is in relation to the committee's inquiry into the mental health of ADF serving personnel. Copies of the committee's terms of reference are available from the secretariat. I welcome everyone here today. In the room today we have Senators Lambie, Fawcett, Gallacher and Whish-Wilson. This is a public hearing and a *Hansard* transcript of proceedings is being made.

Before the committee starts taking evidence I remind all witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to a committee.

I would like to emphasise that, while the committee prefers all evidence to be given in public, under the Senate's resolutions witnesses have the right to request to be heard in private session. If you would like any of your evidence to be heard in-camera please do not hesitate to let the committee know.

If a witness objects to answering a question the witness should state the ground upon which the objection is taken and the committee will determine whether it will insist on an answer, having regard to the ground which is claimed. If the committee determines to insist on an answer a witness may request that the answer be given in-camera. As noted previously, such a request may be made at any other time.

I remind people in the hearing room to ensure their mobile phones are either turned off or switched to silent.

I welcome representatives from Returned Services League of Australia. Would either or both of you like to make a brief opening statement before we go to questions?

Rear Adm. Doolan: I will take the opportunity, if I may, to make an opening statement.

CHAIR: Thank you. Proceed.

Rear Adm. Doolan: The Returned Services League of Australia has, for just on 100 years, been coping with the aftermath of war in terms of the mental health of those who have been in harm's way on behalf of the nation, starting from a shoulder to cry on for those suffering from what was then called shell shock in World War I through to today where veterans in need of assistance, because of their psychological and mental state following operational service in various parts around the world, go to various RSL outlets such as the veterans centre here in Woden in Canberra, the veterans centre in Sydney in East Sydney and various other places, not the least of which is Mates4Mates, a subsidiary run by and funded by the RSL branch in Queensland where professional help by psychologists and psychiatrists and others is arranged for them. This is an ongoing challenge for the league and we will continue doing that into the future.

The substance of our submission to this committee is based on that very long experience. That said, there is much still to be done and we have outlined some of the things in our submission to your committee.

In saying that, we recognise and accept that the enormous challenge that it is, there is a lot of work being done by many others in this space. We certainly acknowledge the work being done within the Australian Defence Force and the Department of Defence to combat the consequences of mental trauma resulting from operational service and we do the same for those working in the Department of Veterans' Affairs, and we applaud the fact that those two departments now are increasingly working together to try to resolve and assist those people in that need.

In our submission there was an attachment produced by Mr Geoffrey Evans from Homes for Heroes for the RSL. Mr Evans is a person who has suffered mental complications as a consequence of his operational service and regrettably cannot be here today to talk about his submission, so we would ask that you accept that submission as it is. We are not in a position to comment on that particular one.

If you turn to our submission, in relation to page 6 where reference is made to the numbers of veterans seeking RSL support for the last financial year just in New South Wales alone, state branch for the RSL veterans centre in East Sydney has assisted 1,320 serving and ex-serving members with their DVA claims and, of those, 721 have presented with one or more mental health issues. We will continue, through our outlets, to work towards that end of helping these people with mental consequences from their operational service.

The final point I would make, which is not covered in our submission, is that since that submission was put together the RSL has been looking at the whole of mental health as a part of health overall for veterans and we are

now in the process of preparing a skeleton paper, a framework paper, for looking at a new way of looking at the totality of health of those who serve in the ADF from the time they are recruited through until the time they expire. We are hoping that out of this will come a new approach to the delivery of health services for those who join the ADF, and those who are ex-serving after that, through life, and I am quite happy to talk a little bit about that should members of the committee so wish. That is all I have to say in my opening statement. Thank you, Chair.

CHAIR: Thank you very much.

Senator WHISH-WILSON: Rear Adm. Doolan, could you give us an idea of the kind of funding that the RSL is providing to some of the groups such as Homes for Heroes and Mates4Mates that you mentioned, the spontaneous veterans community groups that are set up to help veterans with mental health illnesses?

Rear Adm. Doolan: The only answer I can give is that, because we are a federated organisation where the funds provided are provided principally by the state branches but also by sub-branches, I cannot give you a complete breakdown. What I can say is that with the funds that are being provided for Mates4Mates, that Mates4Mates was set up and totally funded and still is totally funded by the Queensland branch of the RSL. It runs into the millions of dollars to set that particular organisation up.

The East Sydney veterans centre is totally funded at this moment by the North Bondi sub-branch. Again, I do not have figures for that, simply because in company terms, although I am the chair of the national company, I have only moral authority over that and I do not have access to those figures.

Senator WHISH-WILSON: As you said, unfortunately Mr Evans cannot be here today but could you talk to the committee about the evolution of that service? I understand you helped to fund it. You said the East Bondi RSL provided the funding which got it off the ground. Did they come to you and your organisation understood the need for this kind of service? I mean this is particularly for housing.

Rear Adm. Doolan: I will turn to my colleague in a minute for that but there are two things here to make sure you are clear on this one. Mr Evans's organisation is quite separate from the East Sydney veterans centre, which again is quite separate from the Woden Valley veterans centre here, which again is quite separate from those run by the Victorian branch. It is what happens in a federation. I will ask Mr Hodges if he can add to that.

Cmdr Hodges: Homes for Heroes was actually established by RSL LifeCare in New South Wales. RSL LifeCare is an aged care facility plus also nursing homes and retirement villages. Predominantly the big one is at Narrabeen which is called War Vets. They have been expanding quite some way throughout New South Wales and into the ACT.

It is interesting that RSL LifeCare started in the First World War and its first premises was Bare Island in Botany Bay where there were no aged care people. They were not old. They were only 30 to 40, the veterans of the First World War, so it is an interesting cycle that RSL LifeCare, that for years and years and years has been a provider of aged care services, has basically gone back to its roots of providing for the younger veterans.

I am not quite sure of the figures—and I think it is in Mr Evans's submission—but out at Narrabeen there are 20 or 30 homes for veterans and their families. This is the big thing; it is not only for the veterans that have fallen on hard times and at risk of homelessness or are homeless but also the veterans' families as well. Homes for Heroes is expanding throughout New South Wales and hopefully Australia but, like the admiral said, it is purely funded by RSL LifeCare.

Senator WHISH-WILSON: So, are you helping to fund that expansion?

Cmdr Hodges: The RSL LifeCare, yes. So, there is the RSL state branch in New South Wales and then RSL LifeCare. They are two separate companies. There are a couple of state councillors from RSL state branch on the LifeCare board but it is a completely different company.

Senator WHISH-WILSON: Could you give us an idea of the type of funding that RSL LifeCare is putting into this?

Cmdr Hodges: I would have to take that one on notice. I am not sure of that one but I dare say it is in their financials.

Senator WHISH-WILSON: In your submission you discuss veteran homelessness, asserting that the number of homeless veterans is considerably higher than the numbers acknowledged by DVA. Can you give us an idea or an estimate of that?

Cmdr Hodges: This is very, very difficult, as I think everyone knows.

Senator WHISH-WILSON: Part of what we want to get to in the inquiry is whether we have the suitable data to determine these things in the first place and how we get that, so it may be the case that you just do not have that data.

Cmdr Hodges: We cannot answer that question. I doubt anybody can answer that question. We and other ex-service organisations and other people who help in the community are constantly trying to get data on this. There is a place in Brisbane. We have a halfway house, if I can call it that, where homeless veterans come in off the street, spend a couple of nights and then go out again. Some of them do not wish to be known in terms of who they are. That is the way they prefer life. So, getting hard data on this we find exceedingly difficult and it would be very remiss of either of us to give you any inclination that we had hard data on this.

Senator WHISH-WILSON: Is there any way of solving that problem in terms of some of your recommendations you have made, for example, around every service person being issued a DVA file number, regardless of the acceptance of time limits?

Rear Adm. Doolan: There are ways that this is happening and it is happening into the future. There has been a change in the relationship between Defence and DVA whereby, as people exit Defence, hitherto there was a case of opting in to have their information passed to DVA. That has now changed to opting out and my understanding, from briefings I have received, is that now 70 per cent of those leaving the Defence Force are opting in to have that information passed across, but that is a personal choice and for those 30 per cent who opt out we do not have data as to why they do. That is their personal choice. Again, we are in the realms of making sure that from here we do not try to give this committee information which is a guess. We just do not know the numbers.

Senator WHISH-WILSON: In your submission you say the numbers are likely to be a lot higher than the DVA numbers.

Rear Adm. Doolan: All we can do is make that estimation. If we had hard data we would have provided it. The hard data that I have made available to you in our opening statement was because I felt that we needed, where we could, to provide that and with the 721 that I quoted, we can actually stand behind that figure, but those are only people who present to us in that particular facility. We are gradually gaining data but there is still a long way to go in convincing people that the system would be better off for them if that data was provided. We are playing catch-up. We have been playing catch-up since World War I.

Senator WHISH-WILSON: Did you want to say something about that, Cmdr. Hodges?

Cmdr Hodges: No.

Senator WHISH-WILSON: It was an excellent submission and you have a number of recommendations in there, as does Homes for Heroes. Firstly, should I say, you also acknowledge in your submission that we have had parliamentary inquiries into these issues previously and you expressed disappointment that previous inquiries have not had the recommendations taken up by government, so thank you for coming again. For example, one of your recommendations is that every service person be issued with a DVA file number regardless of the acceptance of any entitlements. Have these been already discussed with government? Are these new recommendations?

Cmdr Hodges: No, they are not. One of the problems that DVA and Defence have in tracking people is the fact that when you are in the service you have your official number and then when you put a claim in for DVA you get another number, a DVA number. The problem is that if you are in service and you have a service related injury or disease and you put a claim in, you then end up with two numbers and they never marry or match. The RSL has, for quite a few years—

CHAIR: Just on that point, has anybody asked why you end up with two numbers?

Cmdr Hodges: It is history.

CHAIR: There is no logic?

Cmdr Hodges: As I understand it, when the DVA claim system first started they needed numbers, a number for their claimants. For some reason, and I do not know why, they did not take the logical one, which was their official number. Now, with credit to DVA, they are looking at that now and trying to actually get one number and the one number will be their official service number that they carry through.

Rear Adm. Doolan: Could I just interject to put the point that that question about those two numbers is one that really, in a way, the RSL should not be answering. That is outside our bailiwick. It really is a matter for Defence and DVA.

CHAIR: I understand that but when a sort of bolt of common sense is presented we like to capture that moment. I will pursue it in other avenues.

Rear Adm. Doolan: The last thing the RSL would want to do is to mislead the committee by giving in evidence that which we really should not be giving.

Senator WHISH-WILSON: In relation to PTSD your submission makes the point in several sections to support the use of evidence based treatments as treatment of choice for PTSD. Can you comment? Are there specific examples of non-evidence based treatments that are occurring at present that you could mention to the committee?

Cmdr Hodges: Not off the top of my head. The medical side of our submission was collated and put together by Dr Rod Bain, who is the RSL's medical adviser, and he would be here except that he is on holidays overseas. He has extensive knowledge on the treatment of PTSD. He liaises quite a bit with Joint Health Command. All the evidence that he has gathered from people like Phoenix Australia, in terms of traumatic and mental health, has indicated to him that evidence based treatment is the one that should work.

CHAIR: I just want to go to Senator Lambie for a moment and then we will come back.

Senator LAMBIE: Good morning, gentlemen. I just have a few questions. This is for you, Rear Admiral Doolan. Do you accept that between 1948 and 1993 between 20,000 and 30,000 children aged 15 and older were sworn into the Army, Navy and RAAF and served as apprentices and that many of those children, during their training, were subjected to physical, psychological and sexual abuse while in the care of the Australian government?

Rear Adm. Doolan: I would have to take that question on notice. We do not have statistics to be able to give a firm answer to that. We are aware of inquiries, particularly those undertaken most recently with the DART inquiry into that particular issue, but we do not have sufficient information and knowledge to be able to give you a firm answer on that.

Senator LAMBIE: So, would it concern you that you, being the RSL national president and you also being an ex-serving member, if the current royal commission examining child abuse in different Australian institutions failed to conduct hearings which examined the abuse of children who served in the Australian military between 1948 and 1993?

Rear Adm. Doolan: If I understand the question correctly: would it concern me if the commission did not examine cases? If that is the question then, yes, it would concern the RSL.

Senator LAMBIE: So, would you support my call for the current royal commission examining child abuse to conduct hearings which examine the abuse of children who served in the Australian military between 1948 and 1993?

Rear Adm. Doolan: The RSL has supported all the approaches that have been taken thus far and would continue to support any approach that inquired into issues such as the one you raise.

Senator LAMBIE: Are you aware of the secret reporting to a defence abuse, the DLA Piper volume 2, which has been kept secret even from the chiefs of Defence?

Rear Adm. Doolan: I cannot answer that question and there is no point in my taking it on notice because I do not have any ability to answer that question.

Senator LAMBIE: Just in relation to Mr Evans that we were speaking about before in reference to homelessness, it has come to my attention that the RSL LifeCare is prepared to provide housing or a roof over the head of those that are homeless but they are struggling to get the $400,000 that is needed on a yearly basis from Veterans Affairs, from the minister himself, to establish the physical and psychological help that is needed to go into that program. Are you aware that RSL LifeCare has offered to do that but DVA will not meet them in the middle and provide $400,000 so they can have the counselling services and they can have the rehabilitation providers that they need around that area so they can get on with actually having this program up and running at 100 per cent?

Cmdr Hodges: I have no knowledge of that, I am sorry, no.

Rear Adm. Doolan: I would make the point that, although the submission from Mr Evans came in with our submission, it is for Mr Evans to comment on those issues.

Senator LAMBIE: Do you believe that, if a Gold card was issued to all those who have done war and war-like service for their country, that would prevent further physical and psychological abuse to these people that are already suffering under physical and psychological situations? Do you believe by giving them a Gold card as part of their service for war or war-like services would help eliminate this problem?

Rear Adm. Doolan: The RSL, as I indicated in my opening address, is reviewing the totality of the cost effectiveness of the health of all who serve in the Australian Defence Force. We are taking that approach because of the fragmented approach that currently exists for the provision of health services.

The Australian Defence Force is a quite unique body of men and women. If my information is correct, 51 per cent of those called up in the conscription at the time of the Vietnam war were found to be either psychologically or physically unable to serve or were rejected, if I can put it that way, for service in the Australian Defence Force. If you extrapolate that out, that means that the men and women who are recruited into the Australian Defence Force are, in fact, a unique body of men and women who are physically in the top flight of this nation. The consequences of their service, whether it be in training before deployment or during deployment, are well documented and what we, in the RSL, are now looking at, rather than looking at a Gold card, we are looking at the totality of the health provided and the money spent by the taxpayer on providing that health from the time they are recruited through until the time they expire.

That is a huge task but it is important, we believe, that we look at it in a new light. In other words, we are looking at it from the point of view of the wellbeing of those persons throughout their lives and to do that we need to consider a whole new approach to the way we, Australia, provide their health service through those lives. We do not underestimate the challenge that we have placed on ourselves to try to look at this particular issue because what it takes into account is the cost of the health services provided in recruiting, through service and through after service. It also takes into account the avoidance, if at all possible, of litigation that occurs after people leave service when they are seeking to get benefits such as those provided by the Gold card. So, that is the approach that we are taking at the moment and I am hopeful that with the assistance of various people, including people we have recently talked to and I will be making public in due course, that we will be able to come forward with some sort of plan for the future, hopefully in some form or other later on this year or early next year.

Senator LAMBIE: Do you believe that the battle to secure Gold card health benefits and coverage for our war veterans causes them more psychological harm and contributes to suicides?

Rear Adm. Doolan: I can but reiterate the approach that we are now taking to this. We believe a completely new look is needed. To what extent that changes current arrangements with Gold cards and White cards and other aspects will remain to be seen.

When you are looking at the amount of money that is spent it is huge. Virtually half the DVA budget is spent on health related issues; some $6 billion in the last budget. Add to that what is spent in service. We ask ourselves: is the totality of that sum being spent in the most cost-effective way? That is the question that we are addressing and we are trying to bring on board all the expertise that we can in doing that and, indeed, I have already opened up discussions with people including the Australian Medical Association.

Senator LAMBIE: Is the RSL aware of the systematic phase within DVA, when it comes to the delay, the under or over payments of a war veteran's entitlements and pensions causing unnecessary harm and homelessness?

Rear Adm. Doolan: The current system of arrangements whereby applications are made is part of this issue I was talking about. It is a fragmented system. It is imperfect. A lot of people are trying to do a lot in this space and we believe the only way to resolve the issue is to take a totally fresh approach to it in the way that I have described.

Senator LAMBIE: Can you describe what sort of transition there is between your Defence service and them being put back out to the civilian world, because they tell me that Defence has a transition period and that they are doing things in that area to help those transition back into civilian life but, quite frankly, I cannot find any notes on it. I cannot see exactly what they are doing, so could you inform me of what exactly is going on during that transition phase?

Rear Adm. Doolan: Some have described the transition from leaving Defence and going into the civilian world or re-entering the civilian world is like falling off a cliff. We, in the RSL, continue to monitor that. Those of us who have served have experienced this ourselves and we are working with both the Department of Defence and with the Department of Veterans' Affairs to try, as best we can, to make a smooth and effective transition.

I go back to what I have been saying about the approach we are taking because, if you have a new system of through-life health care then that transition will be much eased because it is in the area of health, particularly mental health, which this committee is inquiring into, that some of the real problems exist. A person who has a mental health problem is in need of that assistance through that particular period because if they have been, for example, in the service for say 20 years then they have enormous challenges as they leave the Defence Force to re-establish themselves in a civilian capacity and part of that, if they have a mental health problem, is going to be

doubly difficult for them. So, I reiterate what I said before. We believe that a brand new and a totally new approach to this is at least worth looking at. Now, whether we can come up with something that is cost effective and get away from what I might call entitlements rather than to through-life health care and the wellbeing through life of people in the Defence Force remains to be seen. There may be no more cost-effective method of doing it. We do not know that until we have done our investigations.

CHAIR: I am going to rotate the questioning a bit. One question on the same matter and then Senator Fawcett.

Senator WHISH-WILSON: This is just a follow-up from Senator Lambie's question about the role the RSL plays in something like mental health. How many young vets are members of RSLs these days? You have a long history and you talked about that when you introduced. Are some of these groups we have seen set up, like Soldier On and others, been set up because vets are not necessarily coming to RSLs like they used to 20, 30, 40 or 50 years ago?

Rear Adm. Doolan: The answer in numbers I cannot give you specifically but it is in the thousands. We have recent veterans, contemporary veterans or call them what you will, who are now moving into positions in sub-branches as presidents and as members of the committee, and increasingly they are playing a part in the RSL across the spectrum. We set up, some four or five years ago, the Defence Virtual Sub-Branch which is where there are thousands who are currently still in service. We do have extensive contact with those who are in service. I see them when I visit sub-branches. I see them in various other functions. We have young veterans' forums in which we participate where they talk to us about things.

I provided just recently to the leadership of Defence a statistic which, if memory serves, gives an indication of this. There was something of the order of $320,000 which was given for various needs to serving and ex-serving members by one state in the period January to August of this year for welfare needs, and that ranged from things like assisting them with house maintenance during periods of family trauma right the way through. Some of those sums were in the tens of thousands of dollars. The breakdown of that $320,000 was roughly $160,000 was given to people serving in the ADF at the moment.

I would also remind members of this committee that the RSL was very actively involved last year with the Australian Defence Force in the Invictus Games. That saw not only serving but ex-serving members who were both physically and psychologically damaged as a consequence of their operational service sent to the UK to participate in those very successful games where over 30 nations participated.

CHAIR: I need to go to Senator Fawcett. If it is the wish of the committee, we will continue a bit over time.

Senator FAWCETT: In your submission you talk a bit about the MOU between Defence and DVA. You state that with regard to the specific sections in the MOU the operating principles are not being adhered to as written. Can you give us a bit more detail as to what you mean by that and the implications of it?

Rear Adm. Doolan: I will hand that one to Mr Hodges.

Cmdr Hodges: The MOU was a great concept and start off point for DVA and Defence to sort of link together more for the benefit of those served, the veterans and the DVA clients. The RSL is totally for it, with it, strove for it and supported it immensely. What we have discovered—and this was some investigation that Dr Rod Bain has done—is that it has been much of a closed shop in the fact that we in the ex-service community who are the beneficiary of this closer relationship between Defence and DVA are not really quite sure what is going on, how it is actually operating and whether it is giving the same benefits behind the scenes. As the National Veterans Affairs Advisor, I am very concerned about what is happening day-to-day, grassroots, how our guys and gals are being treated—all that type of thing. But, of course, that has to be formulated behind the scenes like with this MOU. As you can see, there are quite a few things in it that we just cannot see that it is doing anything. In this era of sort of 'jointness' between the ex-service organisations, Defence and DVA, it would be nice to be able to see what is happening so that we the ex-service community can actually say, 'That's probably a good idea, but it really probably won't work down the track. Have you thought about doing it this way?', as an example, but we have got no knowledge and we cannot see how it is working. That is the general flavour of our submission in the MOU.

Senator FAWCETT: You talk specifically about claims and say that too many people are still being discharged from the ADF on medical grounds and the liability by DVA has not been determined at the time of discharge. Can you flesh out 'too many'? Do you have a numerical figure? Do you have a percentage?

Cmdr Hodges: With the mental health of serving and ex-serving members of the Australian Defence Force I see two major problems. One is the fact that the boys and girls who have a mental health issue do not come forward for many, many reasons, which we have all read about and all know. Even though we have tremendous systems in place—the government, DVA, Defence and the RSL—to treat people once they put their hand up, the

problem is getting them to put their hand up. Getting them to think in their mind's eye, 'No, I'm not a wimp if I put my hand up because I've got a mental problem. You didn't say anything about it when I jumped out of a perfectly serviceable aeroplane and broke my leg. I wasn't a wimp then. Why am I being looked at as a wimp now?'

In saying that, Defence is changing its culture. No problem at all. I am fully aware of the fact from the hierarchy down, and you see things on Facebook and things on Twitter from Chief of Army, Navy, Air Force and Chief of the Defence Force saying, 'No, you're not weak if you've got a mental illness', but there is still that perception. It is driven by the community. There is still that perception out there that you are weak, and that is why a lot of guys and girls do not put their hands up to get treated. That is my one hobbyhorse.

The second hobbyhorse is what you have just mentioned. Far too often, when people put their hands up and say, 'Yes, I do have this disease', they are treated in Defence and, of course, they are no longer deployable, so they are due for a medical discharge. My contention is they are not discharged until their claims have gone through DVA, they have been accepted by DVA, their claim for superannuation has gone through ComSuper, has been accepted by ComSuper. When that is done, on day 1 they leave. Day 1 minus 1 is their first day of civilian life and their pay packet is there. That is the big problem. Too often veterans are falling through the cracks and being discharged before all their entitlements are paid. They are the majority that people like the RSL are having to pick up. That is where the money that is raised on Anzac Day and Remembrance Day from the people jingling their little things in the streets is going, to actually pick up this gap when a guy or gal is discharged and the entitlements have not come in yet. As towards numbers, I do not really know the number, but it is enough to keep us employed, that is for sure.

Senator FAWCETT: The two points you have raised are important, because you say here, 'Too many people are being discharged on medical grounds when the liability hasn't been established.' Now, going back to the Joint Standing Committee on Foreign Affairs, Defence and Trade, in the inquiry into wounded and ill soldiers it was one of our recommendations to make sure that that did not occur. But it is not clear from your evidence whether the people that the RSL is picking up are that cohort who have not identified to Defence that they have a problem. So they have discharged, which may not be on medical grounds, and then two years, five years, 10 years later are seeking support, or whether they are people who have identified, have been discharged on medical grounds and that has not been closed.

Cmdr Hodges: Both.

Senator FAWCETT: Do you have any numbers of the people you are working with as to how many are in the former case, that they have not disclosed it, were discharged and now they have suddenly realised that there is a problem, and how many are in that situation where they have disclosed it but the discharge has occurred without DVA being in the loop?

Rear Adm. Doolan: While Mr Hodges is trying to see if we have any data on this, may I just jump in with another observation. These statistics keep on changing simply because even today we are still finding people who, for the first time, are showing mental consequences of service in Vietnam, for example. I have had a couple of recent cases brought to my attention where there had been no issue until quite recently and suddenly, for good and explainable reasons persons, are now showing with this sort of thing. The two things are not tied together. They cannot be at this remove.

In the RSL, we do not usually keep statistics overall. Again, it is a case of, in an ideal world, yes, we would and we have been able to quote some statistics to you here this morning, but the reality of it is that, by and large, we are trying to play catch-up at the same time as I have also indicated to the committee that we are taking a completely fresh look at this. If we can get that to our own satisfaction to a stage where we can recommend that the nation goes forward as a new dynamic in this area, then there will not be this cliff that you come across; in other words, there will be a continuative—

Senator FAWCETT: I accept that and I fully support and welcome the way you are approaching it. The point that I am getting at is this is a big problem and we resolve it one bite at a time. One of the bites we took was to try and close this gap of discharge on medical grounds for DVA. On the face of it, from what you have written here, it says that the problem has not been fixed. In our discussions, you are not quite sure. It is important for us to try and understand that because if in fact Defence and DVA have closed that gap that is great. That is one bite that we do not have to come back to. But these inquiries are important 'ground truthing', if you like, to understand whether what was recommended has actually occurred or not. That is why I am just trying to get to the nub of this. You said here, 'Too many people are still being discharged on medical grounds without the DVA connection', and I am just trying to understand, of the cohort that you are looking at with the RSL, do you have any sense for how many of those are actually in that situation or how many have not been discharged on medical grounds because they

have not disclosed—and I accept completely that is a huge problem—and we are now playing catch-up with that cohort?

Cmdr Hodges: I am pretty sure I can get the numbers from the various state branches for the numbers of veterans they are assisting in a welfare capacity who have fallen through that gap. The gap has not been closed. It has not.

Senator FAWCETT: If you could take that on notice that would be great.

Cmdr Hodges: I will.

Rear Adm. Doolan: We will take that on notice.

CHAIR: Senator Fawcett, I will draw your attention to the time. Is it the wish of the committee to pursue another couple of questions each? Senator Whish-Wilson, do you have another question?

Senator WHISH-WILSON: I think Senator Fawcett has gone to the extent that some of these recommendations from previous inquiries that have been raised have not been followed through. I was going to ask about early intervention. I think you have raised some of these issues around stigma and also potential career limiting choices being made by serving personnel when they raise these issues in Defence and whether anything can be done about that. I think it is probably best served for questions on notice.

CHAIR: Senator Lambie and then back to Senator Fawcett to finish.

Senator LAMBIE: Do you believe one of the reasons they do not come forward about their physical and mental illnesses is because they are treated so appallingly by the DVA when they do come forward? What I am saying there is simply this. I do not know how many veterans I stand in front of, some of them have done six or seven tours, and they are standing in front of me saying, 'I would rather face the Taliban than Veterans' Affairs themselves.' I think that just sums it up. We have a problem. We have a massive problem in Veterans' Affairs. That is the first thing. I am not sure whether you know the numbers, but we have 1,800 people now working in Veterans' Affairs, and I believe in 1990 it had 16,000 workers. We have a problem. We have a chaotic situation in Veterans' Affairs. You must know this, Rear Adm. Doolan. What is your take on it?

Rear Adm. Doolan: We work as closely as we can with all the organs of government, including the Department of Veterans' Affairs. We work as best we can on behalf of those who come to us and represent to the Department of Veterans' Affairs issues that are raised to us on a regular basis. I do this at the level of the secretary very frequently. Mr Hodges is constantly in touch with Veterans' Affairs about a range of issues. It is an imperfect system. I do not accept the word 'appalling' that you applied to it. Are there shortcomings? Of course there are shortcomings. We recognise that. The Department of Veterans' Affairs recognises that. We work with them in a cooperative manner to try to get outcomes which are the best that could be obtained under current legislation. That is always the issue where veterans are concerned.

I come back to this business that I talked about before. We do not see a way around this except by revising the totality of the system, because the system that exists at the moment provides a confrontational issue between veterans seeking entitlements and those in the department protecting the legislation and, therefore, protecting the public purse. What we are looking at, therefore—and I must return to this time and time again—is that the current system, we believe, is fragmented. It does not work in totality and we believe, therefore, the onus is on us to come up with something which will improve the system. That is why I have tried to outline it to you here this morning.

Senator WHISH-WILSON: On that point, are you looking at any systems overseas as a benchmark for this total rejig of the system?

Rear Adm. Doolan: At the outset of this I am personally writing the skeleton paper for this at the moment and, yes, we will obviously be looking at this. But let me hasten to add two things. One is that we are not looking at any change to what exists at the moment in terms of entitlements. I want to make absolutely sure everybody understands that. In other words, those who are on the special rate—we would not be looking at changing that. So, anything we recommend will be recommended from a start date sometime in the future to change the totality.

Are we looking at what happens in the United States of America and Canada? We have not as yet but, yes, we are. I indicated in my opening statement that we were seeking to do this on the broadest possible front and that is exactly what we are doing. We do not see how the current situation can do anything other than remain fragmented, and some of the issues that are raised to you are also raised to us. Mr Hodges and myself and all the other members of the RSL in leadership positions frequently have these things raised to us. We do our level best to try to represent those people; we support them when they go before the Veterans' Review Board, through the Administrative Appeals Tribunal. As one person put to me after they fought four years for this, they would really rather have the four years back than the lump sum which the Commonwealth granted when they got to the courts.

As a consequence of going to court, at the last moment the Commonwealth decided to make a lump sum agreement so it did not actually go before the court. These things happen. We do not know how to get around that except with this new approach.

Senator FAWCETT: I will put a couple of these on notice to save a bit of time, which I know the chair is concerned about. You make a comment in your submission about 30 doctors leaving because of the eHealth system. Can you take on notice how you came up with the figure of 30 doctors and how you can tie that to the eHealth system?

Rear Adm. Doolan: Yes, we can take that on notice.

Senator FAWCETT: With respect to the issue that you raise about reservists having access to psychological screening, my understanding is that reservists have exactly the same access to screening, the Return to Australia Psychological Screen and the Post Operational Psychological Screen, as well as the ongoing pilot which has just been extended to the Reserve Assistance program. If you are aware of reservists who feel as though they have not been given access to that could you come back to us on notice?

Rear Adm. Doolan: Yes, we will take that on notice.

Senator FAWCETT: Finally, you say on page 17 of your submission that the MOU is a great attempt to resolve things, but you mention the fact that both DVA and Defence are hamstrung by a third federal government department, being the Department of Finance. Can you briefly explain what you mean by that and particularly if you have some practical examples of what that hamstringing looks like.

Rear Adm. Doolan: Yes. We will take that as well.

Senator LAMBIE: I have one more question.

CHAIR: Senator Lambie, you have one question before we conclude.

Senator LAMBIE: Just recently, Mr Doolan, I met with a former captain who was rescued from homelessness by Mr Evans. This young Iraqi veteran was living in a tent on the south coast of New South Wales, because he was not being paid the correct amount of his entitlements by DVA. Is it the case that you know underpayments and delayed payments by this government are causing homelessness?

Rear Adm. Doolan: Individual cases come to the RSL on almost a daily basis, things like that caused by a whole variety of reasons, and whenever those are represented to us they are immediately taken up with the relevant authorities in the Department of Veterans' Affairs. I am unaware of the particular case that you have raised, but if that has not been resolved then certainly Mr Hodges, who is the National Veterans' Affairs Advisor, will take that on notice, pick it up and chase it.

Senator LAMBIE: You must be aware that these overpayments and underpayments are happening all over the place. Some of these blokes have bills for $200,000. You must be aware of this. It is not just one. This is happening in many cases. The government is failing to address this issue and it is actually financially straining them. They are taking their own lives, because of these overpayment systems that are going on. They are having to pay this back. It is taking DVA five to 10 years to come back and tell them they have been overpaying them and by then those amounts are horrendous.

Rear Adm. Doolan: The RSL, as a voluntary organisation, does the best we can to pick up each one of those as they come to our notice. We represent those, as I said, on a daily basis sometimes. We are aware of those people who come to us and talk to us about these things. Our pension officers, our welfare officers, our advocates in each of the sub-branches—and there are about 1,200 sub-branches around this nation—deal with that on a day-to-day basis.

What we have done in recent years is to streamline the process. Previously we had an archaic system which backlogged those things and brought them forward in a block towards the end of the year. Now those matters are dealt with as they arise and where there is a matter of policy which has to go forward to government then that is represented through Mr Hodges to me and I take it forward, first and foremost to the department and then, if need be, to the minister.

Senator LAMBIE: Mr Doolan, sticking up for a failed system is not being honest and that is not going to fix the system. We will continue to have suicides out there. To decide to write a white paper now—where have you been all those years? I think that is a fair question.

CHAIR: Rear Admiral Doolan has been very professional and is answering all of the question. I think at that point we will thank you very much for appearing today. We would ask you to stay behind for a few moments in case the secretariat needs to clarify any matters with you. If you have taken questions on notice, you have a

reasonable amount of time to answer them. We have not set a date for return. Thank you very much for your appearance here today.

JAMISON, Colonel David, National Spokesperson, Alliance of Defence Service Organisations

McLAUGHLIN, Mr Noel, Chairman, The Royal Australian Armoured Corps Corporation

Evidence from Colonel Jamison was taken via teleconference—

[9:55]

CHAIR: We now welcome representatives from the Alliance of Defence Service Organisations and the Royal Australian Armoured Corps Corporation.

Mr McLaughlin: I appear today as the Chairman of the Royal Australian Armoured Corps Corporation, representing 12 Unit Associations who support the Regiments and Squadrons of the Royal Australian Armoured Corps. While the Royal Australian Armoured Corps Corporation and the Regimental Associations support many serving personnel, I am not representing the Army.

Col. Jamison: I am retired Colonel David Jamison representing the Alliance of Defence Service Organisations.

CHAIR: Excellent. I was not aware you were coming through the ether, but I certainly am now. Would either of you like to make a brief opening statement?

Col. Jamison: I would like to make a couple of points and then allow Mr McLaughlin to make the opening statement. Firstly, we are concerned about the lack of coordination of support for ex-serving people in the area of mental health services. There are many programs, but there is no real coordination of their provision or any easy way for people to access information about support services that might be applicable to them.

Secondly, there is no easy way to identify veterans once they have left the service and particularly when they are not a DVA client. We believe there needs to be some sort of ID card or identification system to help us there.

The third point that I would like to make is that the ADF has withdrawn what we might call intimate medical support from operational units, particularly in the Army, and the medical officers that used to be part of the infantry battalions have been withdrawn. That is causing an issue with the Royal Australian Regiment Association. I would like to allow, if you would not mind, Mr McLaughlin to make the opening statement.

CHAIR: Mr McLaughlin, you can proceed with your opening statement. I do advise you to make it as brief as possible so that we can have as much questioning as possible.

Mr McLaughlin: Thank you. I have prepared a statement here, which I would like to tender also as a hard copy in evidence. I am aware that there is a five-minute limit. I managed to get to 6.32. If, with the chair's indulgence, you can allow me the extra 92 seconds, I would be most grateful.

CHAIR: Yes.

Mr McLaughlin: I wish to address three things: resilience, PTSD and homelessness.

In addressing resilience, I refer to a comment by General Carl von Clausewitz:

> Kind-hearted people might of course think that there was some ingenious way to disarm or defeat an enemy without too much bloodshed, and might imagine this is the true goal of the art of war. Pleasant as it sounds, it is a fallacy that must be exposed: war is such a dangerous business that the mistakes which come from kindness are the very worst.

As an organisation, the Army has a term and condition of employment no civilian employment has—namely, as a soldier, you are expected to die for your country. An Army is a very peculiar entity, as opposed to public corporations and other civilian enterprises. It kills people and breaks things. That is its nature. It is a brutal application of our nation's foreign policy and, as such, the Army expects its members to do and see things completely beyond the scope and comprehension of the ordinary person.

The Army is, as opposed to the other branches of the Defence Force, an organisation that conducts its business up close and personal with the enemy. That is why resilience is critical to the survival not only of the individual soldier but whole units of the Army as well.

Self-discipline and unit discipline, development of team/unit cohesion and mutual respect and support are critical elements in maintaining the requisite degree of resilience in the face of such awfulness. Soldiering is not for the fainthearted. It is a very demanding profession. It has to be.

To that end, the Army must be a fighting force into which not only toughness and fitness, both physical and mental, through hard training must be ingrained, but more importantly to have resilience inculcated into all members to enable them to withstand the psychological and physical impacts of battle, to enable soldiers to survive and come out the other side of contact with the enemy.

Warfare does not allow soldiers the luxury of grieving for lost mates. Indeed, it mandates through training and drills that the minutiae of details which must be undertaken post battle continue. This is, in itself, a type of coping mechanism, enabling soldiers to continue with their tasks, be it conflict, humanitarian assistance or disaster relief operations.

It is vital to our nation's ongoing security that our soldiers receive the best possible training there is, regardless of how harsh and difficult that training is. It is important that recent ADF scandals are not used as a tool to dilute the impact and effectiveness of hard and challenging training. It is critical to organisational survival that developing a high level of resilience in soldiers to survive the mental and physical impacts of battle continues. The mantra from my former commanding officer, 'train hard, fight easy', rings true to this day.

The challenge facing everyone in the ADF and in civilian life is how to channel resilience developed in the most hostile working environment, a war zone, into a positive resilience continuum for Defence members discharging from the ADF. This is essential in order to enhance reintegration into society outside the cloistered and highly disciplined environment of the Army and other services and to ensure discharge is made less traumatic for members, their families and loved ones.

PTSD is a scourge. There is no other word to describe it. It is pernicious, debilitating, demotivating and destroys lives without compunction. It kills careers. It does not discriminate on the grounds of rank or status in society. It is a hair shirt worn by those who are affected by it.

PTSD is further contributed to by pain from wounds and injuries incurred during one's military career, creating a circular feeding frenzy where one condition feeds off the other, denying veterans respite or peace of mind from the impact of their service. For veterans diagnosed with PTSD, life is like a never-ending PowerPoint presentation in their heads. The effects of PTSD on veterans and their families is ruinous.

Equally importantly, Defence members who have not rendered operational service must also form part of the inquiry for the reasons set out at page 14 of the corporation's submission. The RAAC Corporation reiterates its contention that due weight should also be given to these members as well.

I move to homelessness.

The effects of PTSD on veterans, families and friends are catastrophic. Violent outbursts, depression, emotional numbing, familial and societal withdrawal, the tripwire effect, alcohol and drug abuse all conspire to create an environment forcing families to walk on eggshells around their loved ones, not knowing what it is they have done wrong to create what some families describe to me as a monster in their midst, a complete stranger.

The development of secondary PTSD among family members is a sequela to the PTSD suffered by the primary victim, the veteran. The destruction of the family unit is, in my view, attributable to veterans leaving the family home and living on the streets. The issue of homelessness is a disturbing one. We have personnel who sign on the dotted line to serve their country well and faithfully, even at risk of sacrificing their lives in the service of their nation, now humiliatingly homeless. Additionally, due to the unique nature of military service—and more particularly, in the corporation's case, soldiering—the spectre of homelessness which has afflicted returning veterans since post World War I compounds the sense of compassion we feel towards our less fortunate brothers and sisters in arms.

We must also consider the awful effect homelessness has on the homeless veteran and his or her mates and families. To have homeless veterans in the 21st century is, on any level, too awful to comprehend. This is a stain on a society which historically holds its serving and former Defence members in the affections of our collective national heart and consciousness.

In closing, I have regard to the words of the great Chinese general and military strategist Sun Tzu, which have particular resonance when putting these inquiries before the inquiry, the government of the day and successive governments:

Regard your soldiers as your children, and they will follow you into the deepest valleys; look on them as your own beloved sons …

Defence members who render operational and non-operational service to keep our nation safe are and always will be our beloved sons and beloved daughters. We should support and respect them as we would our own children. We owe them that much. I commend my opening statement to the committee and welcome discussion and comment on our submission. Thank you.

CHAIR: Thank you for that, Mr McLaughlin. It is the intention that we will allocate 10 minutes each. Who would like to open the questions?

Senator LAMBIE: Colonel Jamison, if the Australian government is going to send our soldiers to war in hostile peacekeeping situations, is it then the government's duty to properly look after those soldiers when they come home and discharge, and are this government and previous governments properly looking after our former soldiers?

Col. Jamison: The very reason we are having this inquiry is that there are problems in supporting former soldiers, sailors and airmen and also some of our serving personnel. This issue is a blight on our commitment to our men and women of the ADF. We need to do all in our power to ensure that they get the support needed. Health support and particularly mental health support are the areas that I think we should prioritise and do something about. There should be no more barriers placed in the way of a veteran, particularly, for receiving the necessary health support to overcome the conditions that came about because of the service they gave to this nation.

Senator LAMBIE: Because of the relatively low numbers of full-time ADF members, do you believe that too few are being asked to do too much and being guaranteed a certain level of psychological harm when compared with previous conflicts like Malaysia, Indonesia and Vietnam? Is it fair to say that our younger veterans over the last 15 years have spent more time serving in warlike or war zones?

Col. Jamison: Certainly there are certain elements of the ADF who have carried a heavier burden than other areas, particularly in the special forces area and in specialist areas, and they will wear those scars more heavily than others in the ADF. It is probably not reasonable for me to give an opinion about how ADF members are used or deployed by the commanders of the ADF. That is for them to answer. But certainly I have been told—and it seems to me to be true—that we now have men and women in the ADF who spent more combat time during their service than those during the Second World War on average.

Senator LAMBIE: You are aware that this government and the previous government have forced some of these guys to do eight to 10 tours, which is four to five years in a war zone? Four to five years is an incredible amount of time, considering that the majority of our Vietnam veterans did one year. We only have to see the damage that has been done to them over the last 50 years because of that one year of service, let alone the two years that some of those men did. If we look at that compared to now, where some of them have done four or five years in the war zone, we are in a lot of trouble here, aren't we, if we do not start looking after these men and women?

Col. Jamison: We need to look after them. We need to make sure there are no barriers to their accessing support in the health services area in particular. We need to look at how we can remove those barriers. Rear Admiral Doolan from the RSL mentioned the adversarial system that we are faced with. That is a real issue. If there were some way to remove the adversarial aspect to receiving health support, particularly, or support from the Department of Veterans' Affairs, we should really investigate that very clearly, very closely, and do what we can to remove that aspect and remove any barriers. The provision of comprehensive health support for a veteran once they have served in an operational area and have qualifying service should be a prime area where we ought to be looking.

Senator LAMBIE: So, while PTSD can happen from just one incident, would it be fair to say that the longer a digger spends serving in warlike or war zones the more it increases the risk of that digger contracting PTSD and the severity of that PTSD?

Col. Jamison: I really do not understand enough about mental health issues to be able to answer that properly. It is for a medical expert who has intimate knowledge of PTSD and the impacts of service in the ADF to give you advice on that area. We all have our opinions, but I am not sure they are all that helpful.

Senator LAMBIE: As part of a responsible duty of care, do you think there should be a maximum number of years that our Australian Defence Force personnel should or could spend in warlike or war conditions?

Col. Jamison: I cannot give you an answer to that. I think we all understand there are dangers to prolonged exposure to operational service, but I think we have to be really careful about the conclusions we draw there, and really it is an issue for the government of the day and for the commanders of the ADF to ensure that they are properly looking after their people and in their deployments they are not overloading, if you like, one element of the Defence Force unnecessarily.

Senator LAMBIE: Do you believe that as part of a responsible duty of care there should be a minimum period of time that our Australian Defence Force personnel can spend with their families or on recreational leave before being ordered to serve or re-serve in warlike or war conditions?

Col. Jamison: I think so. I think the ADF recognises that. I am not quite sure of the exact period that they say should lapse before a person is redeployed, but again it depends on the circumstances. It depends on the urgency

of the situation and the need of the operating forces in the operational area itself. Certainly if there is insufficient time between deployments and if there is insufficient time with family we end up with not just mental health problems; we end up with family issues as well, and that just compounds the whole problem.

Senator LAMBIE: Do you believe that the government should be able to cover up the numbers and reasons for veteran suicides and also those that have been locked in jails as to why we are not accounting for those people that are now behind bars? We have no idea of the numbers of those who have served who are veterans who are currently serving time behind bars.

Col. Jamison: Yes. That is a sad reality that we are facing, and that is one of the reasons that we would like to see some sort of veteran ID that would allow people who are in the justice system or in the jail system to identify as veterans so that we can get to them and provide them with the support they need. It is a failure of the system in many ways when somebody gets to a homeless situation or gets incarcerated. We have to do everything we can to obviate the circumstances that lead to that outcome.

Senator LAMBIE: Would you agree that former soldier Aaron Gray, who runs an online veteran suicide register, is accurate in saying that 127 former Australian or serving Australian Defence personnel are already listed as having taken their own lives since the register was made public seven months ago? Of the 68 veterans whose units are cited, half of them served with the 1st, 2nd and 3rd Battalions, which form part of Townsville's 3rd Brigade.

Col. Jamison: The short answer is that I cannot answer that question. I just do not know enough about it. I hate to see the suicides happening and I do not understand how we can allow this to continue the way it is. Again, we have to do everything we can to try and prevent them. We do not need to have bureaucratic blockages to providing the support that is necessary to help these people get through their life.

Senator LAMBIE: Do you believe that giving these people who have served in war and warlike zones an automatic Gold Card would be beneficial to assisting both in the suicide area and in supporting those who need psychological treatment a lot quicker? Right now they are taking a lot of time and having to fight for this. Do you think that it would be a much better alternative to give an automatic Gold Card to those people who have served in war or warlike zones? I can assure you that my studies tell me that it would be cost neutral. I would have to ask why the government is not even looking into this.

Mr McLaughlin: Perhaps I could assist there. There are two regimes here for the Gold Card. You are looking at the special rate under this MRCA 2004 or you are looking at the Gold Card regime under the Veterans' Entitlements Act 1986. There is a substantial body of case law the whole way to the Full Court of the Federal Court, and it is consistent with the black letter law laid down that a Gold Card at 100 per cent of the general rate, then intermediate and TPI is issued subject to specific legislative criteria. At age 70 there is an automatic entitlement for a Gold Card for veterans who attain that age, God bless them, provided they have rendered qualifying service. You would have to be very careful how you would issue a Gold Card outside those parameters, because the intent of parliament at the time was to make the granting and conditions of that card to people who had actually seen what they call the sharp end of service, as Justice Beaumont said in a case; they are more beneficially entitled to it than somebody who has not.

My understanding from the Gold Card issue under MRCA 2004 is it applies only to the special rate because, as legislation, it is a dog of an act and has nothing to benefit the veterans at all. It only benefits deceased veterans' families financially and allows a TPI style veteran 10 hours remunerated work per week compared to eight hours with the other one.

The Gold Card is a very contentious area. Whether it would reduce suicides or not, I do not know. I think what has to happen is a massive culture change within the Repatriation Commission to their adversarial approach towards veterans, and I speak with the benefit of qualified privilege of 29 years at the sharp end in that regard.

Col. Jamison: Just to add to what Mr McLaughlin said, certainly the issue of a Gold Card on discharge for those with qualifying service would remove a major cause of adversarial dealings between the veteran and the department. It is something that I think needs to be looked at, because it would simply extend the sort of health support that is available during service to a veteran for the remainder of his or her life up to age 70 when they then qualify for that anyway.

Senator WHISH-WILSON: I have some specific questions on your submission, but I just wanted to dob you in, I suppose, firstly. When I asked a question of the RSL at the last briefing I saw you vigorously nodding your head at something I asked. The RSL is obviously a very important institution and will play quite a big role in some of the outcomes that we want to achieve from this inquiry in terms of its ability to bring people together and

its lobbying power. I asked about whether younger veterans were not attracted to the RSL or their numbers were not as high as in previous years. How effective is it with younger veterans as an organisation?

Mr McLaughlin: I speak as a life member of the league. I joined it in 1969 after my first tour of duty in Vietnam and was treated like everybody else—like a piece of dirt. I guess you could say that a lot of these young diggers today who have seen operational service come from families where they have had their dads or their uncles or their older brothers actually return from operational service in Vietnam and have seen how they have been treated. They have become well organised, as I stated in my submission, under other ESOs. They are very savvy and very much aware.

The national president mentioned contemporary veterans. That is seen in the context of Operation Slipper in Iraq and Afghanistan, but I take the view from 30 April 1975 forward, after the North Vietnamese finally invaded Saigon for the last time and got into the presidential palace—from that date onwards, in my view and in my corporation's view, everybody is a contemporary veteran from that conflict onwards.

There are tens of thousands of veterans out there, men and women, who have served in numerous peacekeeping operations. In my experience there is a big disconnect between the younger veterans and the league. They see an organisation, the old and bold, that they cannot relate to. That is the same with any conflict you go into. It would be the same with the senator's colleagues from her Army service. She would relate to them and not people from somewhere else within the Army at the same time. They are her mates. That will always happen.

As for an overarching ex-service organisation, the league is not what it was, in my personal opinion, and I do not believe that the numbers that the national president is citing are truly representative from post April 1975.

Senator WHISH-WILSON: So, if they are going to be doing a large study and an overhaul of the system or a refreshment of the system, as was mentioned, how important is it that they get the feedback from contemporary veterans as you define them?

Mr McLaughlin: It is critical. It is definitely critical. I must acknowledge—and I do not think anybody would disagree with me—that they are still seen as the lead advocacy organisation in the country. Without a doubt they have the numbers, but there are other younger organisations. Ours is not even three years old. We are still toddling, but we do see the need for a complete reset button being applied to the Repatriation Commission. It is an organisation that is not user friendly. It is an organisation that is adversarial. It is populated by incompetent decision making, lazy decision making, no respect for the culture of care that this country owes its soldiers, which goes back to my concluding remarks from that bill, post World War I, which I have put in my final page under the conclusion in my submission. There is a lot of work to be done there. There is a lot of catching up, but compared to the British system or the American system it is the best in the world, in my view. It is not perfect, but it needs to be sheep dogged by the ESOs and by government. It needs to be brought into the 21st century.

Senator WHISH-WILSON: In relation to paragraph (c) of the terms of reference, mental health evaluation and counselling services available to returned service personnel, ADSO understands the services available to returned personnel to be adequate in the main. The real issue appears to be access to service providers who have an empathy with and can relate to veterans in a way that gains their confidence. Could one of you elaborate a little more on that and whether the outsourcing and privatisation of these kinds of services over the years is the issue with empathy? Could you expand on that a bit?

Col. Jamison: Putting something out to a Sydney firm like that means one thing: they are in it to make a buck. Let us be cold blooded and brutal about that. That is a fact of life. They are there to earn money, to employ their staff to look after the likes of service personnel discharging who require their help. It definitely needs to be empathetic, without a doubt. The VVCS does an absolutely fantastic job, but it is fighting an increasing tide of traumatised veterans and traumatised families. There do not appear to be enough people to help this increasing tide. We are lucky in one set of circumstances that a lot of people will stay in the system and make a career out of it. That acts as a security blanket.

Senator WHISH-WILSON: Do we know if there are many of them left?

Col. Jamison: In my experience quite a few. The people that I am talking about at the moment have a minimum of 35 years in and they are enjoying life, but the day will come when they leave and when they march out on discharge or retirement it is a very cold wind that blows down your back, from experience, and it is then when the system no longer owes the retired service member a duty of care, they are just another face in the crowd with no rank and no status, they are just a Mr, a Mrs or a Ms, a nothing—that is when the reality kicks in. That is the falling off the cliff that somebody alluded to a while ago, and that is very traumatic.

Senator WHISH-WILSON: You mentioned that obviously on the private service provider side they are making a buck, but you could flip that on its head and also say that perhaps DVA or the government is trying to save a buck by outsourcing them in the first place.

Col. Jamison: They owe us a duty. I would agree. There has to be a balance struck somewhere. How we strike that balance, you will need a real financial whiz kid to do that. Stalin said you've got to break an egg to make an omelette, and there is a lot to be said in its application to looking after former service personnel and currently serving service personnel. The advice I have received from my client base is that the in-house stuff when members return from an operational deployment is working. It is a success story. But the sad thing is we do not hear about the success stories in the press. We just hear about the negative stories through the ABC and the like, which damage the good work done and which also damage employment prospects for former serving personnel. That has been alluded to by Garth Callender in his book *After the Blast*, which deals with one of my topics, occult brain injuries, and in which he noted with disbelief the huge disconnect within the reality and rhetoric of employers snapping ex-service members up like that. He has seen it as not real, and I think the publicity which is positive in that it is out there and people know about it now, that this is something that is an illness. It needs to be treated. It is an insult to the system, but at the same time employers look twice at an ex-service applicant thinking, 'What have I got here?' It is a double-edged sword.

Senator WHISH-WILSON: How important is housing support services? Do you agree with Homes for Heroes and their Housing First principle?

Col. Jamison: Absolutely. When I did the research in preparing the submission I was blown away by the stats I saw on their website. I think they should be put on a plinth and made saints. In fact, I am aware that the Queensland branch of the state RSL are looking very carefully at that model. They have $34 million in their bank account. They are not short of a quid or two. I think if they can get it up through their state executives and run a pilot program that would be brilliant, but other ESOs do not have that sort of money, and I am assuming some of the state branches may not either. It may come down to a situation where the government might be able to assist with funding. To me I see the Homes for Heroes as being the lead. We would contend that government consider that and look to probably helping to set it up/underwrite it.

Senator WHISH-WILSON: And through that RSL LifeCare model rolling out like a national coordination program rather than just having it administered ad hoc?

Mr McLaughlin: Absolutely. The Regimental Sergeant Major of the Army emailed me the other day and he is trying to comprehend the 3,000 homeless. He cannot climb over it. It is a heck of a shock to him, and that is the senior non-commissioned soldier in the Army. He is having a significant amount of trouble coming to terms with that, and I think anybody would, when I have a full colonel who wants to live homeless and shows us the spot where he is going to live.

Col. Jamison: I can support Mr McLaughlin's remarks there. The Homes for Heroes model, which is a holistic model, providing support in terms of accommodation but also requiring the individual to commit to a treatment program with the aim of full rehabilitation of the individual and the family is a very worthwhile approach. I know the Queensland RSL state branch, in conjunction with the other major ESOs in that state, are looking at how they might be able to replicate something like that in that state and perhaps exported to other states around the country. It is a very worthwhile and a very cost-effective way of doing it, and it is something that I think that the Veteran Affairs' Department needs to seriously consider supporting financially.

Senator WHISH-WILSON: I might put some questions on notice. I was particularly interested in your submission calling for a review of the Privacy Act in relation to ADF medical records and the mental fitness of personnel in active service being shared with senior command, and also your recommendation for a single identification card for veterans. Perhaps you could just quickly touch on the second one. I will give you a more detailed question on the first one, if that is possible.

Mr McLaughlin: I did not put anything in about the national identity card, as I call it. I have a concern about that as being a pseudo Stasi-like Australia Card that was intended to be introduced years back. But with the mental health and the effect on serving personnel, they will not report it. They will not do a thing about it because they want to soldier on. They have their career. I have a client who is a two-star officer. He made it unambiguously clear to me that he was not going to tell the little RAAF temporary reserve psychologist at his debriefing what she wanted to hear. I said, 'Why?' and he said, 'Because I'm ready for promotion. I don't want to see my career go up in smoke.'

Senator WHISH-WILSON: So, if this kind of private information was shared it would be more of a barrier to them actually opening up?

Mr McLaughlin: I believe so. It has also adversely affected one other soldier who has gone through the ranks to the rank of major. He was a tank driver. The leopard tank rolled on a night move. The loader operator on the turret on the left-hand side was thrown halfway up the turret and crushed to death. The driver, the crew commander and the gunner were rescued unhurt. He soldiered on. He went through the ranks and achieved the rank of major and he is doing fantastic things. I found out when he was out sailing the yacht he was on lurched to one side suddenly on a swell, on the side to which he rolled. It created a flashback nearly 40 years down the track. He was not feeling too well. He reported and he sought treatment. He was informed it was a compensable situation and he should put a compensation claim in. He did. The compensation agency then sends a request to the Army to seek the member's medical documents to help process the claim for PTSD. The next thing the member gets a notice to show why he should not be discharged. The Chief of Defence's signal, which I have lauded quite honestly in my submission, has a lot going for it, but the reality is people are not and will not talk about this while they are in the system. It is only when they get out. As I have said, I have quoted one colonel that I took instructions from. It is a well-founded fear of being persecuted, vilified and ridiculed by your peers, subordinates and superiors. It is a career killer. I speak from personal experience.

Senator FAWCETT: In your opening statement I think Colonel Jamison talked about the need for greater coordination. Given that the title of this inquiry is 'The mental health of ADF serving personnel', would you care to comment on the soldier recovery centres and whether you think that is a model that should be continued/expanded into other locations so that serving members and their families have access to the information and services that they need?

Mr McLaughlin: I do, sir, and I draw the committee's attention to a document titled 'Post-operational debriefing in the Australian Army', by Jennifer Medbury. It is from the *Australian Army Journal* Volume V, No. 3, Summer 2008. It goes from pages 53 to 64. I commend that the soldier recovery centres are obviously brilliant. They should without a doubt be opened up to the members' families as well, because the members' families are looking after a loved one who is serving a bigger family. The fact that there does not appear to be a sufficient joining there of the member and their family in the recovery centres—without a doubt we have to do something. We owe it to the member and his or her partner and their children to try to keep the family unit whole, to try to keep them together, to make them functioning members of society post discharge, post-retirement, and to keep them off the streets from living rough or living in the back of a utility. I commend that and I would like to tender it in evidence if I may please.

Senator FAWCETT: I notice in your submission you talk about the surprising lack of knowledge of veterans—and by this I am assuming you mean serving members who are veterans of operational service—that their spouse or partner or able to access counselling sessions. My understanding from visits to soldier recovery centres is that families can access them. Can you give us some understanding as to what measures you think would need to be brought in to increase the awareness of serving members that their spouses are actually eligible to access services?

Mr McLaughlin: Without a doubt, more publicity. I speak from experience as an advocate here in taking instructions from clients. We meet the client's spouse and/or partner and family members and we brief them on what is available to them. You would be amazed at the amount of veterans that, firstly, do not even know that their other half can go there; and, secondly, their other half do not know they can access it, either. It is quite surprising out there at the coalface.

It needs more education. It needs to be brought into military units with Safe Base Charlie, as it is. The access to ESOs to brief soldiers informally. Access by the VBCS to the bases. It is gone. You cannot get in. Yes, there is the on-base advisory services, but my advice to soldiers sometimes is that I would not go there. If you are seen going there to see a DVA officer somebody will see you and think you are a squeaky wheel and the next thing you have a knife between your shoulder blades.

In the advocacy community the Repatriation Commission is seen by many as the enemy. That is a genuine fear. I have spoken to soldiers who in fact are reluctant to go to an OBAS in case they are seen. That is a concern to me too. Once again, it sort of counterbalances what Air Marshal Binskin said in his excellent signal. I think the fact he put it out there took a lot of courage—an awful lot of courage to do that for a system that is very rigid and very hierarchical and based on the Roman modelling of soldiering. A weak one goes by the wayside, to say that; but at the same time it is to try and cure the inherent distrust. We need to get the families and we need to get external agencies, not government agencies, external non-government agencies, into the major military areas.

Col. Jamison: If I could just add to that. The ADF seems to have a problem communicating down to its lowest levels to try and get messages through. We saw that during the last wage case where the DFWA and ADSO managed to get its message out to over 60,000 people, and the ADF message and a series of seminars was

attended by only 3,000. There is an issue there, but there is also a cultural issue of how to handle people who have particularly mental health problems within the system. The stigma needs to be taken away. It needs to be seen in the same light as a physical injury where treatment and rehabilitation are the issue, and support from the command structure is absolutely crucial for that. Understanding the issue and people that are at risk and do have those sorts of problems by the command structure is something that we were alluding to in the Privacy Act issue, but it needs to be done within the culture of here is somebody who is a worthwhile contributor to the ADF who at this stage of his service or her service needs adequate support in a particular aspect of life to enable that person to continue serving in a very effective way. We have to get away from, 'There's a problem there. Let's get rid of the problem', because that is self-defeating.

Senator FAWCETT: As a starting point at the moment all ADF personnel, in fact Defence personnel, civilian and military, need to do mandatory equity and diversity training on a regular basis with things like fraud awareness. If we brought in a component on a similar basis looking at indicators and mental health services available, with services available to families and so on, would that be a starting point that you would support?

Col. Jamison: I would like to think so, but unfortunately the training space within the ADF is now so crowded with that sort of imperative and requirement that it would get lost in the noise. I would like to know what the answer is, because I do not have it myself.

Senator FAWCETT: I will just move to a different topic, children of contemporary veterans. I think the RSL talked about the fact that children of Vietnam veterans can access VVCS services regardless of age but others cut off at 26. Do you have an evidence base of children of veterans seeking support who are not receiving support and should we be changing that entitlement?

Col. Jamison: I think Mr McLaughlin might be better placed to answer that.

Senator FAWCETT: He is shaking his head.

Col. Jamison: No. I have not been approached by any clients in the 29 years about their children experiencing difficulty in accessing services. I have alluded to the suffering of children of veterans in our submission, but nothing has come near it. That is why I think we need to get these non-government ESOs on the bases of information nights, family nights or whatever to get it out there. It is a crying shame it cuts out at 26. PTSD is for life. There is no cure to it. You can live with it. It will not kill you, but the other things that it generates will. We need to have it, because the children of Vietnam veterans were found to have a higher rate in society of suicide, risk of suicide, than children of non-Vietnam veterans. I would be petrified if that actually found its way through to children of contemporary veterans as well.

Senator FAWCETT: Very briefly, you contend in the strongest possible terms that a joint venture initiative between ESOs and DVA be considered with a view to developing outreach camps for children of contemporary veterans.

Mr McLaughlin: Yes.

Senator FAWCETT: Do you have a particular model there that you are looking at, an understanding of cost, who would be engaged and so on? Perhaps if you take that on notice may be the best way.

Mr McLaughlin: I can recall one. I sent my son on it way back in the mid-eighties. It was the best thing he ever did. He came back with a full appreciation of what it is like to live with a father with PTSD. I could not send my younger son on it because he was below the age limit. My eldest boy never looked back from that. He never looked back at all. Outreach, outdoors stuff, physically challenging activities, the building of team cohesion, the bonding, let the kids sit around the campfire at night and have a cup of coffee and just talk it out and have counsellors on board. I have seen the same thing with inmates. I spent 14 years in the corrections industry and I have seen inmates at the end of an 80 kilometre walking track not wanting to say goodbye to each other, yet they would not give each other the time of day in the yards.

It works. We need to have more of it, but it has to be joint. I think it needs to be a joint venture. The initiatives that I have suggested, the outreach areas, the rest areas that I have added to the submission need to be looked at. They are there to be tapped into. They are there for any veteran. They do not have to be a Vietnam veteran.

Senator FAWCETT: My final question I will ask you to take on notice. In your submission you talk about the privacy of medical information, and you refer to the Germanwings flight incident. My reading of the Privacy Act, particularly section 16A(1), items (i) and (vii), indicate to me that it does not necessarily apply to the military in the way that you have asserted. Can I ask you to perhaps go and have a look at that again and come back to the committee?

Mr McLaughlin: The Privacy Act is not in my submission. I did not allude to that at all in my submission.

Col. Jamison: That is in our submission. Certainly we would be prepared to have another look at that.

Senator FAWCETT: If you could. It was section 16A(1) items (i) and (vii). From my reading of it, I am not convinced that that is necessarily the case. If you could have a look at that and give us your opinion that would be great.

CHAIR: All right. Thank you very much for appearing here today. In case the secretariat needs to clarify any matters with you, could you remain behind for a couple of minutes.

Senator LAMBIE: Can I ask a question about offsetting? I think it is really important that we get a grasp on the offsetting. If I could just have a couple of minutes for offsetting?

CHAIR: With the committee's indulgence, Senator Lambie to wrap up.

Senator LAMBIE: I am assuming that you men are aware of concerns expressed to me by veterans that some of the members of Defence Force, specifically those who are long serving and covered under a range of different acts for compensation, may not be properly covered if they are injured whilst serving in the Middle East, because of the offsetting provisions. You would also be aware that recently Veterans' Affairs upgraded their systems. It spent $30 million on upgrading their systems to avoid the double-dipping. I am just wondering if you are aware that those offsetting provisions could now be removed, yet Veterans' Affairs have still not removed those offsetting provisions, which is absolutely detrimental to those men and women who have served. The more time they seem to serve the worse that offsetting affects them. Are you aware of those offsetting provisions?

Mr McLaughlin: I am aware of offsetting.

Col. Jamison: There is a difference there between the compensation system and the superannuation system. It is our firm view that there should be no nexus between the compensation system as it applies to the individual and the superannuation provisions. We have long said that the offsetting is wrong.

Mr McLaughlin: I would agree with Colonel Jamieson's statement there. I despise offsetting. The situation at the moment is this. Under the current MRCA 2004, which as I said is a travesty of a piece of legislation—it is just a pure civi compo act disguised as a government piece of legislation—if a soldier is found to be totally and completely incapacitated for work and is granted a notional amount of $1,000 per fortnight disability pension and is receiving their military super, and now they have to be 55 to access it instead of 37—after 20 years—that TPI under the new system is offset by 60 per cent. In real terms in their pocket they are getting $400 notional as opposed to $1,000. They retain the benefits, but when you have a young soldier who cannot touch their pension until they reach an age of 55 and have 20 years worth of pension racked up ready to be accessed and they are trying to put roots down, they are trying to buy a house, put a deposit down and educate their children, and for whatever reason their pension comes through and they have got the TPI—bang, it is lost by 60 per cent. That is utterly indefensible and unconscionable. It is an insult for the soldiers to be deemed to be a double-dipper. It is an insult to a soldier to have to be subjected to what is a civilian compensation regime and treated as a client, managed by claims assessors and not by determining officers as the law calls them. It is disgraceful.

CHAIR: At that point, thank you very much, Colonel Jamison and Mr McLaughlin.

BALE, Mr John Benjamin, Chief Executive Officer and Co-Founder, Soldier On

[10:44]

CHAIR: I welcome Mr John Bale, from Soldier On. Would you like to make a brief opening statement before we go to questions?

Mr Bale: Absolutely. Thank you very much for the opportunity to speak today. Soldier On is an organisation that started quite recently, back in 2012. It started with a co-founder, Cavin, and my wife and I. It came out of a very personal thing for me where a good friend of mine was killed in an IED attack in Afghanistan. What I found out of that situation was that the families or the family in fact of Michael Fussell was incredibly well supported not just by the ADF but also by the community. However, there was a gap between that support and the support that was given to those that were wounded, both physically and unfortunately psychologically post, and there existed organisations overseas, especially Help for Heroes in the UK, the Wounded Warrior Project in the US and other like organisations and an organisation like that just did not exist here in Australia.

The RSL, Legacy and other organisations provide key and fundamental support but they lack that coordination, especially around those with physical and psychological wounds and the support to their families and the way that that could be connected through anyone in the community. So, with that in mind we decided that we would start an organisation through the support of several eminent ex-serving members and current serving. We started the organisation to provide a link between the Australian community and those who have been affected.

As an organisation we have grown rapidly. We now support over 500 veterans and family members a month around the country. We have a centre here in Canberra, Sydney, Melbourne, Adelaide and soon to be started in Perth. We are starting a range of partnerships with organisations around Australia and also internationally to make sure that the support we provide is the best possible.

What we do as an organisation is try to link people on a road to recovery to make sure that they can transition out of the military and into society in a way that is empowering to them as an individual but also supports their family to make sure that they have the best possible chance for an empowering future.

Besides being a Tasmanian, I am also a fourth-generation veteran myself. My great-grandfather was at the battle of Fromelles. My grandfather was a prisoner of war at Changi. My father was a Vietnam veteran and also at the battle of the Coral, and I myself deployed to Afghanistan. For me, personally, I think I have seen, through my own family and being obviously the child of a veteran and a Vietnam veteran at that, that we have gone a long way but we have still got a long way to go in the transitional support that is required. I think that that is a key statement and a key important area that we as an organisation are supporting. We need to do so in a coordinated approach and also inside the system and making sure that DVA and the ADF can be coordinated with other ESOs so it is a holistic approach to transition.

Mental health in the ADF is obviously a key and fundamental thing that has been brought forward not just by our organisation but lots of organisations recently. I think through a range of activities and a range of conversations that have started we now actually recognise that mental health is a key and fundamental part of what the ADF needs to look after, its people, its people's families, and ultimately that that transition to society is important. I do not think the ADF's responsibility stops the moment they walk out the door. There is a responsibility to make sure they walk out that door best prepared for society and also then the transition to DVA and ultimately the other organisations that can support them.

You have seen the submission which identifies a number of areas that we believe could be improved which will allow individuals the ability to access care earlier, to allow to destigmatise mental health injuries and make sure that families are actually included in that support. We believe these things, along with a fully fundamental and I guess important transitional program, will allow people who have been affected by the service to transition out into society, be supported by that society, and we will not have the same issues that we have had through other wars, especially from Vietnam. Thank you.

CHAIR: Thank you, Mr Bale. Before I go to other senators for questions, you mentioned that you want an audit of recordkeeping within DVA. Is it your view that there is no disclosable recordkeeping? Can you expand on that a bit?

Mr Bale: There is a range of areas that we see inside DVA that we feel could be improved, and recordkeeping is one of those. When we have spoken to a number of veterans it seems that sometimes their records are either lost or they are not handed over correctly. When you have a mental health injury, actually talking through the same thing again and again can be quite confronting, especially when you have to relive your wound. So, for whatever reason it seems that records are not passed on correctly. That may mean they are kept correctly but not passed on correctly—

CHAIR: Just on that point, we had a submission earlier that the military service number versus your DVA number are different. Is that solution just too obvious?

Mr Bale: I do not know whether that is the full scope of this issue. I personally think that it is not just the number but also the people inside DVA and/or inside the ADF that are supporting. We need to make sure that that handover—

CHAIR: Two separate silos of records. They are not accessible; is that what you mean?

Mr Bale: I do not know about that, but what I am saying is the individuals who take over responsibility for a person's case and then for whatever reason are away or hand over that case to someone else need to make sure that that handover is seamless for the individual who is the end user. At this stage, from the information we have received from a number of people, that is not the case.

CHAIR: So, they are not actually held on computer records? Is it a case that if someone goes on leave no-one else can access it?

Mr Bale: No. My understanding is that they are held as computer records, but it is not about the recordkeeping. It seems to be that some information gets lost or not transcribed correctly.

Senator LAMBIE: Are you doing much advocacy as such? You are doing your repair programs, aren't you? So, you are not actually doing the claims or are you moving into that area?

Mr Bale: Soldier On is an organisation that started through looking at a gaps analysis as well as the story that I spoke about. We identified that the RSL and Legacy and other organisations do advocacy and do it well. There are ways that they could improve and we could all improve, but we recognise that that was already being done. What was not done was that community connection to people who had been affected, both serving and ex-serving and their families. For us, as an organisation, we want to absolutely make sure that we do what we do and other organisations do what they do. That being said, we need to do it together collectively. That includes government and also obviously the ADF and DVA.

There is a way to go for us as an organisation where we believe we can bring collectively some of those organisations together through our centres and other facilities around the country. You mentioned earlier Homes for Heroes. Support on site to that is something that we were very privileged to start with, and providing that coordinated care across the country I think is a fundamental thing.

Senator LAMBIE: Have you heard of the GI bill that they have in America for their transition? Are you aware of that? So, if you do a qualifying amount of service or you do service for an amount of time you are qualified to be under the GI bill or if you have done war service you are retrained et cetera, before you are put back out on civi street. Some 75 per cent of your wage is paid to you while you are doing that training. They are having a great success rate with that. They have about an 80 per cent success rate, I believe, the last time I looked at figures. Do you believe this would be a good thing between when they leave Defence and back in civilian life for those people who have done war-like service or have done five or six years in uniform?

Mr Bale: I am well aware of the GI bill. My brother actually lives in the US at this moment and obviously his son is looking at that as an option. I think that the Australian Defence Force has actually recognised that transition is fundamental, and that is one of the areas that ultimately the ADF and the DVA were not working on collectively. Organisations external to that I think hold a fundamental part in that, and we have taken on a responsibility through our Hand Up program to make sure that that transition can actually be provided through not just educational opportunities, which are fundamental, not just at the university level, but ultimately at the vocational level as well through diplomas, advanced diplomas, certificates and so on, in allowing people to transition to gainful employment that can be provided by a range of organisations and companies.

I think that something like the GI bill is an option. Ultimately I think the work that we have started but also that Army SWIP and the ADF have started around rehabilitation through employment is already along that pathway. I think, just from our perspective, there needs to be more coordination on that.

Senator LAMBIE: I am sorry, I did not realise the Armed Forces now created a job corps. Is that what you are talking about?

Mr Bale: No, they have not started a job corps. What they have recognised is that employment and transition are fundamental to success especially of those who have been or are about to be medically discharged. Supporting them through their transition is fundamental. I think that is the first step along the road to looking at education and increased education opportunities.

Senator LAMBIE: They are not supporting them. Were you an officer? I am just trying to get this. I realise that officers get more advantage in that situation than diggers do. I am being honest about that. I am quite sure

any digger will tell you that. There is a distinct difference between being an officer and a digger when you are discharged from the Armed Forces.

Mr Bale: I do not think that is the case anymore. My understanding, in speaking to a number of my cohort and veterans—and for the record, I was an officer—is that that transition is being picked up by organisations like ours but also the Defence Force in a coordinated way. They are trying to, across-the-board regardless of rank, provide education, and through organisations like ours and others employment opportunities. Now, that is a pilot. There is a long way to go there, but they are starting down that road.

Senator LAMBIE: So, how do they pay their diggers when they have left the Armed Forces? Who is paying these diggers? Are they just on Centrelink benefits or are these diggers actually receiving training plus some sort of wage on the side as well?

Mr Bale: I think that is a question best for the ADF.

Senator LAMBIE: I have no further questions.

Senator WHISH-WILSON: In your submission you mentioned that one of your key aims when you set up Soldier On was to raise awareness of issues like PTSD, and you gave some examples about physical and mental wounds and the gaps there. You also mentioned that you feel that you have achieved that. That was in the opening letter.

Mr Bale: Yes.

Senator WHISH-WILSON: We have heard today that in terms of the stigma associated with serving Defence personnel raising these issues is a career limiting move and there are still stigmas associated with this. How long do you think it will be if we can get DVA to accept this and we can get the vets community to accept that as a serious issue before it is accepted in the Defence Force that you can speak openly about this and seek treatment or early intervention?

Mr Bale: I think that is the key, early intervention. There are actually a lot of ways that people can get support for their mental health inside the Defence Force. Not all of them are the best ways. There are ways that that could be integrated into what organisations like Soldier On do that could make the outcome for the individual and the family better. However, I do believe that we have increased awareness around PTSD especially or, as we call it, operational stress injury, and also the other injuries that can happen overseas such as a non-medical term, operational stress, anxiety, depression and so on. But there is still a long way to go, especially inside the Defence Force. Stigma comes in two forms. You have public stigma, which obviously in Australia we, as a society, have a long way to work through when it comes to mental health, especially men's mental health, but there is still a significant amount to do inside self-stigma inside the Defence Force as well. That is, as a warrior, as someone who is trained specifically in many instances to kill, I should not as an individual feel these feelings and I do not have to step up to the plate. I should not ever have to because, ultimately, I should have been trained not to feel this. Getting rid of those things early is about an education program that currently does not exist inside the ADF. It also does not exist, I think, inside society, but it certainly does not exist inside the ADF.

What we have tried to do as an organisation is highlight people's mental health, highlight the fact that for them they have hit rock bottom, unfortunately, in many instances and their families have actually told them that they need to seek help, which is the last state that I think, but they have themselves actually sought that help and got to a point where they have recognised that they are at rock bottom and they have gone through and got help through myriad organisations, including ours, and got to an end state.

I think highlighting that you can actually get through this; through adversity you can get to an end state where you are happier, where as a family you can be a unit again and support each other collectively and be an active part of the community is fundamental. I think that conversation, ironically, is actually doing better on the outside about Defence than it is on the inside yet. I think the Defence Force is getting a lot better at this, but there is still not a coordinated and targeted approach to making sure that people recognise that they can put their hand up for mental health issues.

Senator FAWCETT: On that note, one of your key recommendations is the ADF aim to actively treat and address the effects of these combats as a standard operating procedure not on a case by case basis or where concern is identified.

Mr Bale: Yes.

Senator FAWCETT: Is this just assuming that these operations are high risk and that you have a chance, even if you do not report these symptoms when you are discharged, of developing them at some stage? So that it is kind of standardised and depersonalised? Is that what you are suggesting?

Mr Bale: Yes, absolutely. It is a holistic approach. All credit to the ADF. It has, in the last years especially—and I think that we have been a small part of that from an outsider's perspective and from a community perspective—really highlighted that this is an issue. The ADF, to their credit, have really recognised that and started putting in a number of approaches to that. Obviously it is a large organisation. It does take time, and to answer your question earlier correctly, I do not know when, but I think we are on the path to actually achieving a better awareness around mental health.

Specifically here I think that actually educating people when they roll through the door that unfortunately or fortunately they will be put into harm's way. I do not mean 'fortunately' in any bad context, but fortunately in the sense that they joined up for a reason and cause. They are there to help people and ultimately, unfortunately, that can affect them and can affect their families.

So, early education, providing them with that support mechanism early I think would be important but also once you have gone through a traumatic event or even in an operational environment, making sure that you get the support that you need. Yes, you go through your POPS and you go through a number of other psychological screening activities, but recognising that it is okay to get that support immediately or soon after. Some research has been done in the UK around when people were putting their hand up through an organisation called Combat Stress to say that they have mental health issues, it was approximately seven years after the traumatic event. As an organisation what we are trying to do, and the ADF should be doing the same—and I know they are trying—is to make sure people put their hand up as soon as they start to know the symptoms. But to know the symptoms you first have to be educated about them, and I do not think there is enough education inside the Australian Defence Force at this point in time.

Senator WHISH-WILSON: You wrote about education and raising awareness within the veterans community and especially, I suppose, within the contemporary veterans. I am not sure how we define that after our last witness said that it should be 75 onwards. In the opening letter from your chairman and former Chief of Army he said:

> Through various channels, predominantly anecdotal evidence and word of mouth, we received word that in the first 13 weeks of the year 14 veterans took their own lives. These were young men and women who had served in recent conflicts dead by their own hands.

Was that picked up through your networks and how far do you have to go before veterans out there who need help understand that is available through organisations like yours and elsewhere?

Mr Bale: Social media is really how we picked that up and, obviously, through word of mouth. Through these centres now people are connecting, and that is what we are building as a community. One of the previous respondents said that when you take off your uniform you take off you as a person and everything that you stood for, your position in society, and that is so true. We are trying to build up a community, and as a community we start to build up a very concerning picture around people or veterans taking their own lives. That is purely anecdotal. I know it is one of the things that we also highlight in our submission. We need to have a better understanding of how many veterans have taken their lives and are at risk of taking their lives. I know that is difficult and I know DVA is working on that, but the sooner we know that as a society the sooner we can highlight that this is a genuine issue and that more resources can be put into it and we can focus on this.

Senator WHISH-WILSON: But through your own networks and the people that you are working with, do you acknowledge the risks, especially with clients who may have mental health issues, of suicide, substance abuse, homelessness and domestic violence? Is this something that you deal with regularly or are you more about maintaining a community to prevent that kind of thing?

Mr Bale: We are absolutely trying to prevent it, but obviously there are people who have transitioned out of the military who have fallen on very hard times. Some of them transitioned quite well. They thought that they were fine and subsequently the trauma has caught up with them and their families and they have reached out for that support. We do see, unfortunately, many people who have hit rock bottom, as I said earlier, and need that support. We have supported a number of veterans and what we are doing as an organisation—and I think there has been a lot of siloing in the ESO community over as long as ESOs have been around to be honest. What we are trying to do as an organisation—and all the other organisations at this moment in time I feel are doing the same, and also it is a privilege to be working the ADF to achieve this end state as well. It is a bit of a more coordinated approach. So, when someone does come to us out of, for example, the St John of God Richmond PTSD facility, they have no home to go back to. They are struggling with this, that and the other. We can then turn them towards Homes for Heroes and make sure that that transition is as good as possible, to support their family, and if we cannot support them to refer them to Legacy and so on. So, I think there is a collaborative approach which can

achieve an end state, but ultimately for us, if we could support the people in that transition period first, I do not think as many of these issues—they will still exist obviously—will exist as there currently are.

Senator WHISH-WILSON: This is my last question. The chair has been very strict today. We have limited time. In relation to your funding, one of your recommendations was that you would like to see a consistent funding source and that the government consider the services and the gap that you filled. Could you tell the committee a bit more about what kind of funding you might be seeking. Also I am interested as to whether you do receive any funding from the RSL or various branches of the RSL and whether that is something that the RSL could contribute more towards?

Mr Bale: As an organisation we started off very much being supported by the community, and that has been maintained. For us, when we are asking for more government support, it is not specifically for Soldier On. What we would like to see is that the government, and especially the ADF and DVA—and I think they are starting to, which is fantastic—recognise that ESOs are actually fundamental in this space to supporting veterans not only as they transition and have been transitioned but actually while they are serving. That we do this and we do this quite well, because we have a lot of people who have had the bad experiences, if you will, who have been supported through that transition, have come back and want to see things done better and have a range of support mechanisms across-the-board.

So, collectively, I think there is an opportunity for government to look at this sector and say that it could actually support a lot of the issues that you are talking about here today and especially the issues that you spoke about at this committee several years ago through the investigation into wounded, injured and ill and that transition into the veterans community. So, it is not specifically for us as an organisation, but it is for the wider group.

Now, as an organisation we have had about $8,000 at this stage, out of the approximately $7 million we have raised from across the community and corporates, from the Australian government. The rest of the money, as I said, came from the Australian community, but we have also been supported by the RSL and sub-branches of the RSL, and that support has been obviously phenomenal. It has helped us get to this point and now the support is predominantly still from the Australian people in small donations and from corporate Australia as well.

Senator WHISH-WILSON: I suppose with the ESOs that you are referring to there, we have yourselves and Mates4Mates and Homes for Heroes. There are a lot of groups that we are hearing from. Is this a fairly recent phenomenon or has this occurred in the past? I am just wondering if you are a natural reaction to an obvious gap that just was not being filled or whether this has occurred in the past?

Mr Bale: I know it occurred after obviously the world wars, where a huge number of other organisations stood up and then slowly, as they better worked together, recognised what they did and did not do well and started to collaborate better and then actually started to amalgamate, which is a good thing. We are trying to take a leadership position. We have a very influential board, which is fantastic, to be able to make sure that that coordination is done external from government. I do not think that is your responsibility. I think that is our responsibility to make sure that is coordinated, and slowly but surely I think we are starting to achieve that.

From your perspective and from the government's perspective I think that that will be welcomed, because it is quite complex not just for obviously the committee but it is very complex for veterans as well, for the ADF and for the DVA to be looking at a huge number of organisations and saying, 'Who do we work with? When do we work with them?' Ultimately, collectively, we are all trying to work for the same end state and that is for the betterment of the individual who is affected by their service and also their families.

Senator FAWCETT: Given the inquiry is about the mental health of ADF serving personnel, could you just talk briefly about the extent of your engagement with servicemen and women who are actually serving as opposed to those who are transitioning or in the veterans' community?

Mr Bale: When I started the organisation with my wife and a mate I was still a serving member. Obviously supporting members in-service was going to be quite a touchy subject and something that would just not be achievable. Our focus to start with was ex-serving members to make sure we made that delineation but also we recognised that as far as the support mechanisms went and what we were trying to achieve that is where the most amount of need was. We are unapologetic for that. We also recognised, as we were going through, that if we actually supported them earlier through what we did as an organisation, but collectively if the ESOs and other organisations that provide support could get in there earlier, then we think the outcomes for them and their families would be better.

Recently, over especially the last six months, we have really taken on an approach to make sure that we are fundamentally part of what is provided by the Australian Defence Force. Even back at the start we did do some

grants. One of our pillars is to enhance the level of support that exists. We provided a range of mechanisms to the ADF. We bought a range of high-end mountain bikes for the soldier recovery centre in Darwin as well as the high-performance down at 2 Commando, and a range of other things up in the 3rd Brigade as well. We started off in that vein, but now we want to actually highlight our facilities and make sure that they can support ADF members.

One of the biggest things we are doing at the moment, in partnership with Concord Repatriation General Hospital, is to build a national centre of excellence for Defence members and their families who have been affected by this service either with PTSD, traumatic brain injury, physical effects or alcohol or drug abuse, and provide a single node that the individual can be sent from ADF facilities to this facility at Concord with their family, which is a new thing in Australia which has not been done before and comes out of the US out of the centres over there, especially through the Intrepid Fallen Heroes Fund over there, where they have a thing set up for families to stay while the individual is going through rehabilitation. This facility will be integrated into what the ADF is already providing through soldier recovery centres, through its IRTs and other such services on base, through what is done now on base in the ADF. We started to move towards actually supporting members.

A lot of people still come to us as a first point of call, as in ADF members, identifying that for whatever reason they do not want to disclose that they are part of the ADF still. But for them it might not necessarily be about seeking out a psychologist. It might just be to build a connection with others who are going through something similar. It does not have to be purely about, I guess, psychology. There are other facets about building up a case and being on a road to recovery to help them transition, because unfortunately for many they will. But for some we have supported them, still serving members. They have been able to build up a picture that what they are going through is not something they have to do alone, that their families do not have to do it alone and being able to turn them around so that now they are continuing to serve and they are doing so in a happy, healthy way and can go on and do that in the long term.

We are also starting to work with ADF members who have been recommended to us from the ADF, which is a fantastic new thing. Part of what we want to do, as I said upfront, is actually integrate our services, and hopefully then all of the ESOs who we work with, which is the vast majority, and other organisations, so we can be coordinated in a holistic approach.

Senator FAWCETT: Some of the reason for my asking is that we get a number of suggestions for problem sets, gaps that are identified or suggestions as to the way forward, but it is hard to understand sometimes what the mindset of the current serving soldier, sailor or airman is in terms of whether that would be effective. A couple of the things that you have identified here in one of your recommendations are for more comprehensive education around early detection of symptoms. You have mentioned a number of times about families. Do you have a model in mind, from your engagement with servicemen who are currently still in, and what would that look like? How do we most effectively educate the individual and make it accessible to their families?

Mr Bale: I think it has to be something that is done firstly off base. It has to be something that is integrating the family into this approach. For us, it is about building awareness. This is not purely about the organisation Soldier On, but I was very lucky in my last year in the ADF to be Chief of Army Scholar looking at destigmatising PTSD in the Australian Army. One of the things that came out was an approach around a digital and/or in fact complete media solution to this—so social media, traditional media—around a program in the US called Real Warriors and a number of other like programs. If you can build a platform that connects to people in the way that they connect to others, say, through social media, you can start to reach them through education programs. A decentralised model, say, the ADF using organisations like Soldier On to attract people to their facilities to continue this in a face-to-face manner. I think in answering your question, a holistic approach from a communications perspective using all forms of media around a campaign, if you will, to destigmatise this but first step first is to actually educate people on what it is.

Senator FAWCETT: You made a comment here and we have had it in other submissions and indeed in pretty much every inquiry we have done in the last few years; one of the real issues for serving members is they do not want to flag the fact that they are having a problem because of the impact on their career. You make the comment here, in this current submission, that many people in the general population experience mental health issues during their lifetime but continue to maintain rewarding careers and run successful businesses. From your interaction with serving members, do you have a sense for whether the gold standard that people would want would be to be able to flag the issue and continue in their operational career? It has been put to us in a submission for this inquiry that an alternative path could be to say if they wished to pick up some of the old ECNs that have now been replaced by contractors and APS staff, whether it be in catering, logistics or administration, that if the

ADF opened those streams up again to servicemen and women to continue to serve but in those supporting areas, do you have a sense as to whether that would be an attractive proposition?

Mr Bale: Yes, absolutely. I think taking away people's uniform and taking away their rank, their title and their position in the ADF is a really difficult thing for them. For me, they have joined up early and they really identify with that. When they decide to leave, that is a different story. It is still very difficult for some. It does take away, I guess, a sense of purpose and a sense of teamwork and lots of other things, but to still be either directly a part of that, either through transitioning into a skillset that was not your primary aim to be in the Defence Force but still allows you to work with those that you joined up with, that allows you to give back, I think is fundamental. Even to take it a step further, if you can work in industries that are directly aligned with that, say, still work on base, maybe still not wearing the uniform, but contributing in exactly or very close to the same way that you once did. I know that that would be hugely beneficial to a number of veterans to allow them to get that support and take the time to transition out when they want to. I also think that it would be hugely beneficial to the ADF. You are keeping people that we, as a country, have spent a lot of money educating and a lot of money training, to get up to a certain point. You have selected them for a reason. They have been through batches of psychological tests and so on and they have experience that they could pass on not necessarily in that current role but even if it was on to other individuals in their past role, and obviously I think also in their new roles. So, if we could actually look at that from the two-way street, that you are not just throwing them an opportunity to keep them in, but also keeping a lot of IP and a lot of talent in the pool, I think that is a much better way to approach it.

Senator FAWCETT: This will be my last question. You talk about the VVCS and concern about eligibility criteria for people to access it. How much of an issue is it that people actually have to be categorised under DSM-V as having a condition or a problem before they are eligible to be referred or their families? How do you see us moving forward to make sure that early intervention is more feasible?

Mr Bale: I think that is one of the biggest things. You basically have to take on a disorder or whatever it is before you are actually able to achieve that. I think, for me and for the organisation, that is a fundamental stumbling block for people to actually access support. Destigmatisation needs to start at the point where you have some of the symptoms that might lead you to a clinical diagnosis, but ultimately if we could start there and you recognise that you are irritable, that you are quite angry, that all of the other symptoms have not started yet, but you have noticed those or better still your family have noticed and have been through an education program that tells them that these are starting to be the red flags, you can then access support without having to tell your chain of command, without having to go through an MO if you are still serving, and directly go to an organisation, hopefully in-house, so that you do not have to go to individual psychologists that do not necessarily understand what you have been through. If you could go through that and then at the end of that go back into work—obviously if there is a red flag, where there is something that your chain needs to know about, then that is something that I think absolutely still needs to be fail-safed into it. But if you could really pre-emptively allow yourself and your family to recognise these symptoms and they also to get support, I think the end state for the ADF and for the wider community would be much better.

Senator WHISH-WILSON: You may not have an answer to this, but I know our next witnesses are going to be talking about a suicide register and this kind of thing. We touched earlier on the number, through social media, of suicides that you are aware of in the first 13 weeks of the year. Do you have any updates for the committee? Has there been any other information that has come to light in the last six months or so?

Mr Bale: We had, unfortunately, this year two suicides where we actually were supporting the people who took their own lives. I will take your question on notice to make sure the number I give is very specific, because it is important to make sure that it is. But if I could talk to those two. From an organisational perspective, obviously that hit us very hard, and I think if I could leave the committee with this. When you are talking about these it is not just numbers. These people in fact had families.

Senator WHISH-WILSON: Of course.

Mr Bale: And to support them was a true privilege, but we will continue to support as many as we can, because ultimately they have said now that they did not take the same path. But it is a very complicated situation where some of these people have found themselves. It is not completely and 100 per cent sometimes to do with their operational service. It is the stress afterwards that that has placed on the family, the breakdown of the family, the breakdown of the home, the homelessness that can occur and the lack of employment that unfortunately some of them cannot attain. These things ultimately build up and I think if we had a better understanding of how many people were taking their own lives, the reasons that they did, we could actually, as a community and as a government, you could and we could reach out to them and make sure that we support them earlier. Unfortunately we just cannot save everyone. That is a fact. It is an unfortunate fact, but we can do a whole lot better and I am

very proud to say that we have started that process. I know that the ADF has started that process as well, but we do have a long way to go.

Senator LAMBIE: Can I just add one question to that.? In reference to those two people that took their lives, were they dealing with Veterans' Affairs at the time and was that one of the contributing factors on why you believe they have taken their own lives?

Mr Bale: I will take that on notice.

CHAIR: Thank you very much, Mr Bale. If you can just remain behind for a few moments in case the secretariat needs to clarify any matters with you. Anything that has been taken on notice, you have a reasonable amount of time to return. We have not set a date for return of questions on notice. Thank you very much. We will now suspend for a period of 15 minutes to give our Hansard staff a bit of a break.

Committee adjourned from 11:23 to 11:38

MacDONALD, Mrs Emma Louise, Director, Research and Support Foundation, Australian Families of the Military

MacDONALD, Mr Robert James, Deputy Executive Director, Research and Support Foundation, Australian Families of the Military

MacDONELL, Mrs Gail Vicki, Executive Director, Australian Families of the Military

CHAIR: I now welcome representatives from the Australian Families of the Military Research and Support Foundation. Would someone like to make a brief opening statement before we go to questions?

Mrs MacDonell: There are two of us. We will be very brief. Firstly, we would like to thank you for the opportunity to present at this inquiry. AFOM was formed out of a need for high-quality and independent research. Current directors are all current and post serving Defence members or their families. We also do one-on-one referrals for people. We have started to do a lot of that and run workshops on mental health in the community.

I sincerely hope that the outcome of this inquiry brings about the required changes to improve mental health outcomes of our military personnel by overcoming the systems of bureaucracy, the bureaucratic silos and barriers to change. While previous inquiries have brought about increased funding for the mental health workforce, there appears to be less face-to-face support and no increased family resources.

We fully support the national review of mental health in 2014 where they proposed a new system of architecture with a bottom-up approach encompassing person centred design principles and a shift of funding to more efficient and effective upstream services and support. We need a much higher practical emphasis and strategies on maintaining good family relationships and getting rid of the one-size-fits all approach. We have always said healthier families, healthier veterans.

We would strongly urge the instigation of independent research and evaluation of all or any of the changes brought about by this inquiry, and that these changes are looked at over long-term outcomes for military personal and their families with a CQI approach.

Mr MacDonald: Again, thank you for having us and giving us the opportunity to speak today. Initially the ADF is to defend Australia and its national interests. To achieve this, it should reflect the values and beliefs of the society it defends. The Australian values statement articulates respect for the individual, equality under law, equality of men and women, equality of opportunity and peacefulness, and yet, as already mentioned today, despite today being the latest in a long line of reviews and reports with only some advances the ADF is still failing some of its members and their families. The World Health Organisation states mental health is produced socially and therefore requires social as well as individual solutions. Numerous mental health reports and research have highlighted the importance of families for positive outcomes in mental health. We believe there need to be greater family involvement in not just mental health processes but in Defence member decision making, for example, the posting process. There need to be greater volumes of research in Defence life and family. Mental health should be a priority to all Defence, not just deployed members. Non-deployed members are better thought of as potential to be deployed members and as such their mental health is just as important. An increase in local services and an increase in uniformed mental health professionals in all three services.

AFOM exists because there was seen to be a gap for independent research into families and Defence life. We believe Defence families should have the involvement and respect they deserve in policies that look to the future and not stuck sometimes decades in the past. Thank you.

Senator WHISH-WILSON: Mr MacDonald, you were just talking about an increase in—and I will not quote your exact words—or more professional services. We have heard from previous witnesses and the committee has heard from other submissions privately around the privatisation of services over the years for Veterans' Affairs. Are you talking about more in-house professionals?

Mr MacDonald: At this stage the uniformed psychologists—we have an Army corps that has uniformed psychologists. The Army are unique in that. The Air Force and Navy have reservists. I am more looking at uniformed doctors and psychologists on base for members to go to and are willing to speak to, especially for uniformed members who have been on deployment and know where the members are coming from in terms of psychologists and doctors, as opposed to a civilian psychologist that you might be referred to in the civilian world who may have no idea what it is like to be deployed overseas.

Senator WHISH-WILSON: Would these psychologists have specialist training in areas like PTSD?

Mr MacDonald: I would like to think so. I know the Army has a masters program currently with the University of Adelaide which is a Defence Clinical. That came from the Dunt review, which saw a gap in clinical

training for Defence psychologists. That focuses on Defence needs. I would not be able to say how that program is going.

Senator WHISH-WILSON: Senator Fawcett might be able to fill us in on that a little bit later.

Senator FAWCETT: I can, in fact. One of the problems is that Defence has not been able to provide the supervisory positions for those people who have entered the program, so it has not really got past the first cohort. Chief of Army is aware of that and he has actually been very proactive to look at how we can develop that concept a bit further.

Senator WHISH-WILSON: Your submission recommends involving families in routine medical and psychological screening. Can you elaborate for the committee the benefits of that proposal?

Mr MacDonald: Yes. At least some sort of involvement. It could be a survey or the opportunity just to invite to come along to certain things, for example, the post-deployment screening. At the moment there is no real way of bringing your family in. Getting your family onto the base is even particularly difficult in some circumstances. Some way of families to have at least a say in that. I will point out that, as we have already seen, Defence members can be reluctant to bring up issues. That could also be said for families who are reluctant to endanger their family member's career. But at least some sort of option somewhere where they are engaged and are able to give feedback. Many Defence members are able to work quite effectively at work but their lifestyle at home could be changed, and their partner, parents, siblings may notice that whereas people at work would not.

Senator WHISH-WILSON: Could you give the committee an idea of the privacy restrictions in place at the moment for serving personnel between serving personnel and their families?

Mrs MacDonell: As far as I am aware, there is no real connection. If I could go by some of the people that have come to me, they have actually wanted to say, 'I'm worried about my husband and, what's more, he's in the Army and he's got weapons and I'm really worried about him', but there was nothing that they could do without jeopardising maybe his career so it was just left in the open.

Our idea with families is if there was a place where families could come and say, 'Look, my husband is a bit angry lately, a bit jittery and a bit angry', we could look at that in a case-by-case as being angry. They could maybe look at that and have some counselling or some things like that, especially if you have an on base type of social worker who is clued up on all of that. They can then identify further things down the track. More than likely you could probably stop a chain of events where everything builds up. Because until they reach a crisis they do not really know that there is an issue a lot of the time. With the privacy issues, I think you are seeing now that everything is a silo. There are just silos and silos where one person does not know what the other person is doing. This is where I think a lot of the members are getting lost.

Senator WHISH-WILSON: Do you mostly deal with serving Defence personnel or do you also do work with veterans?

Mrs MacDonell: I started off working with veterans and their families for the last 15 to 17 years. In the last five, six or seven years I have been working with families of current serving or just out.

Mr MacDonald: Most of our experience has been with serving members as opposed to Mrs MacDonell.

Mrs MacDonell: He is a current serving member.

Senator WHISH-WILSON: If a serving member is having mental health issues and they have either self-identified or it has been identified some other way, are the families brought into that process at the moment so that they can help that person cope?

Mr MacDonald: Not necessarily.

Mrs MacDonell: No, and this is where we are saying that if you look at the data from overseas and the little bit that has been done in Australia, relationship breakups are one of the highest causes of suicides in the end. If you can keep the family unit together; that like I said, healthier partners, healthier veterans, healthier families. This is one way of accessing that. Families, especially intimate others, are the first ones to pick up on those changes.

Mr MacDonald: The other issue with engaging families with someone who is identified with mental health issues, either themselves or their family—the first question that you are going to ask them is, 'Have you been deployed?' because if they have been deployed or not will significantly change what is open to them to get help for them and their families, especially families. Defence members always have a medical system in place which they can use. It is not for me to talk about that particular medical system, but if you have been deployed it opens up a whole option for your family through VVCS. If you have not been deployed you are sort of restricted to the DCO hotline or a chaplain on base.

Senator WHISH-WILSON: Typically would the family deal directly with people at VVCS themselves or how does it work? Do they have someone who is a go-between?

Mr MacDonald: Again, it is generally left up to the member to know that their family has that option. The family can ring VVCS themselves, but you would normally find the Defence member themselves either does it or tells their family member that they have the option and they can do that.

Senator WHISH-WILSON: And would you see a better system being where the families have that awareness that they can do that directly themselves?

Mrs MacDonell: Yes.

Senator WHISH-WILSON: Have you had any anecdotal evidence you can share with the committee about how those kinds of relationships have gone? We have obviously heard a lot of negative stories about dealing with DVA in general, with getting entitlements and help. Is it an issue for families as well?

Mrs MacDonell: Are you talking about VVCS or DVA?

Senator WHISH-WILSON: VVCS, just generally.

Mrs MacDonell: I have had good feedback about VVCS in general, especially about the family weekend or the couples weekend. That was really good for the older ones, but apparently they are also doing some with the younger ones. The feedback I have had from that was that it was really good and beneficial for both of them. It was accessing—I think as one of the previous people have said—and actually knowing that they are eligible. It seems to be shrouded in secrecy. I would have assumed everyone would know about it, but they really do not.

Senator WHISH-WILSON: Your submission calls for all deployment related mental health and psychiatric disorders to be covered under the umbrella term operational service disorder. Could you elaborate on that a little bit for the committee and have you had these discussions with other people?

Mrs MacDonell: We have had further discussions since we put that in. We have actually called it maybe defence service. It is just an example as a way to decrease the stigma. They were saying that if you say you have PTSD later on down the track people might not employ you or things like that. In Canada they have that kind of system where it is everything from adjustment disorder from when they come back up to acute psychosis is put under that one umbrella, and then no-one really knows what is going on. They think, 'He's okay. He's not too bad.' It actually decreases the stigma of having that.

Senator WHISH-WILSON: Just on that point, how important is that stigma in re-employment of service personnel, especially if they have seen someone? Is it a barrier?

Mrs MacDonell: I think in a lot of cases it is, because they are told that once they have it they cannot get rid of it. I do not know if it is reinforced enough. If you have diabetes you cannot get rid of it either, but you can manage to have a good life with it. It is that quality of life and you can still do other things along the way. That is the kind of thing that I am talking about, but if you actually have PTSD stamped on your forehead then that comes with a lot of other connotations, and they are also fed by other people with PTSD as well.

Senator WHISH-WILSON: I think one of the previous recommendations from a parliamentary inquiry was that the government employ Defence personnel with these mental health issues and work with corporations generally to try and get placements. I am not sure how that is progressing. Maybe Senator Fawcett could update that. It is underway, but I am not sure of where it is at. Clearly that is going to be a big issue for families, if they cannot get employment or it is difficult to get employment with those issues.

Mrs MacDonell: Yes.

Senator WHISH-WILSON: Do I have time for one more question?

CHAIR: Yes.

Senator WHISH-WILSON: Your submission calls for an urgent review of the procedure and follow through of post-deployment assessments. What would adequate post-deployment assessment and support entail? Can you share that with the committee?

Mr MacDonald: Currently we have RtAPS and the POPs, both of which rely heavily on self-referral. Most people know how to answer them before they go there. They are designed to get red flags. They rely heavily on the skills of the person doing the interview with the person coming from the deployment and, again, I have already said that we are short on uniformed personnel experienced in that. We have already heard that people are reluctant to come up with, 'I've got issues.' It generally comes up with, 'Have you got any problems sleeping?' 'No.' Tick, tick, tick, tick. How we do that better, I do not know. I want to see further research into how we again

perhaps bring family into that somehow or some sort of external factor into it where these people would have no choice but to accept. They are usually the last people who know they have an issue.

Again, we are looking at commanders and peers and better education amongst them, who can again pull people up and go, 'Look, there's an issue here.' As I think we have already said in our submission, families are usually the first people to know that something is wrong.

Senator WHISH-WILSON: Yes.

CHAIR: Just on that point, I actually spoke to a couple of soldiers in Afghanistan who said that they go through Al Minhad and they know how to get past the trick cyclist, and they have got all the questions rehearsed and answered and it is basically done. If I know that, the Army knows that so why don't they vary the debriefing to try to get people to be aware that there could be impending problems?

Senator WHISH-WILSON: Remind us again why they are trying to get through these interviews with knowing the answers? Is it because of promotional issues?

Mr MacDonald: It almost starts all the way back at the recruitment process, where you get asked similar questions when you are recruited, 'Do you feel like jumping off high places? Do you want to cross the road to avoid someone?' It starts very early on there where you go, 'I will give the answer they want to hear.' All through your career you know, 'If I give the answers they want to hear I'm not going to get into trouble.' 'How many drinks do you have a week?' 'Two or three beers on a Friday, that's all', and then that's the last you will get questioned on it. 'Do you smoke cigarettes?' 'No', and then that is the last you will be asked on it. If you go further than that it starts to feel like you are going to start jeopardising your career. It can be quite a long process. It does not necessarily mean you are going to lose your career, but if you are looking at 12 months where your career is even stalled it can be difficult to get back.

CHAIR: I know I can have the same sort of discussion with my doctor and when I say, 'Two or three beers on a Friday' he generally laughs. Those responses can be factored into the program. People are not telling you the truth, basically. They are underestimating or conveniently forgetting issues which should be raised, so surely that is a psychiatrist or a psychologist's business.

Mr MacDonald: Yes.

Senator WHISH-WILSON: So why are they getting bluffed?

Mr MacDonald: We are relying heavily on the skills, and they are all exceptionally good but, again, they are overworked. If we look at things like the Special Forces, we know that the jobs that they are doing are dangerous so they will get a focus. We know certain jobs will see people killed and be shot at so they will get a focus. But there are a lot of people who are deployed who do jobs that do not necessarily get these red flags. You might be working in an office overseas in the Middle East. For example, I know with some of the jobs that they having visions of bombings, where they are seeing videos of live bombings with people being shot and killed. Because they are in an office environment and not necessarily in the war zone they will not tick any boxes because they have not been in a gunfight. They are feeling fine.

Senator FAWCETT: In your submission you say you have spoken to current serving members who have stated that they failed to receive a recommended from their recruitment psychology interview and yet were passed on through. You make the comment, essentially, that it is up to the medical officer to give a tick or a cross and the psychologist report can be set aside. Is that on the basis of one interview, your saying that, or do you have other corroborating evidence to show that there is a pattern there that people are coming through the psychological screening without an approval and yet still being accepted?

Mr MacDonald: I only know the couple of instances where I have spoken to people just where I work who have been given a not recommended by the psychologist. I will put in that those people have had successful careers and have not had any issues to this date. The only other evidence I could find was from the Kapooka Army Recruit Training Centre, which detailed the recruitment process, which said the medical and recruitment officer were the only ones who could basically give a not suitable, and so the psychology report was looked at but was not necessarily an end. If you did not get a ‘suitable' the recruitment officer could basically override it.

Senator FAWCETT: In the case of the two people that you spoke to that went on and had successful careers, had they specifically asked to see their psychology report or was that feedback provided to them verbally?

Mr MacDonald: That was provided to them verbally by the recruitment officer.

Senator FAWCETT: You talked about the Joint Health Command Mental Health Psychology Rehabilitation Branch and you talked about relationships. You raised that before. You say that the psychologists only ever admit to working with the ADF members and no sanction for working with families. You then go on to talk about the

ANAO audits of DCO and the fact that they traditionally provide counselling services but now are outsourcing those, and many of the private organisations outside do not want to take new referrals because they are overworked. Do you have any sense for the numbers of families who are seeking support through DCO who then cannot access it because the organisations they are referred to basically are overworked and cannot take them?

Mrs MacDonald: No.

Mrs MacDonell: We cannot get numbers from DCO on anything actually. To be frank, if you try to get numbers from DCO you just do not get them. We can only go on anecdotal things, as I said. In my area there is a community liaison officer that is there maybe two days a week. If someone has an issue they have to be able to get on base to be able to contact that person, then they are referred to somebody else who is referred to somebody else. They just get lost in the system. What there is in the community is a lot of social capital with the people who live in that area. Given some support and some guidance in there, especially with a trained social worker, there could be so much done at the coalface. Given that flexibility, from my point of view, from the dealings that I have had with it and the dealings that people that I work with have had, there is an inflexible object. It is just inflexible. Mrs MacDonald knows a bit more about that.

Mrs MacDonald: No, that is fine.

Mr MacDonald: Mrs MacDonald might be able to talk more about family engagement that she has done. I think from the small bit we have seen people probably will not go to DCO, because they will not be expecting much.

Senator FAWCETT: As in they are not expecting it from DCO or the fact that it is referred to an external provider who does not have capacity?

Mr MacDonald: I think the general attitude is it is not even worth your time talking to DCO in the first place so they will not even try.

Mrs MacDonald: They have got a very narrow intake.

Mrs MacDonell: If you were to go on their website, and I have not been on their website for a while, it says it offers all of these things, but when the families try to access that then you have to have so many numbers before they will do this or they are not able to do that at this time. In a lot of cases that I have been talking to over the last three years they have just kind of walked away from that. Actually they use external people themselves a lot of the time. I try to refer them mostly to VVCS. There could be a lot of things done at a local level—like I said, a social worker that just had that flexibility to look at it, because every place is different. Up in Tindal it is going to be different to where I am in Singleton. It is going to be different down in Williamtown. They should look at what is actually going on. This 'one size fits all' seems to be, 'Ring the hotline and we'll sort it out.' In the audit it said a lot of those people at the end of the audit were not even trained to be able to do counselling.

Senator FAWCETT: We have had a number of people talk to us about VVCS and the fact they do a great job, but that families need to be more aware that they are available and that they can be referred to them without the serviceman having to actually be assessed as having an issue. From your experience, how many families are aware of the early warning signs and are looking for that support before things actually blow up?

Mrs MacDonell: That is probably a hard one to answer, because when I get to see them someone has said, 'Ring Gail and talk to her about it.' You are kind of talking to people who have already seen the warning signs but not recognised them. There does need to be more education and that is why we started doing these invisible wounds, PTSD awareness, depression, anxiety and mental health days in the community. I was surprised at the feedback that we received. I thought these are people in the community and they have been in the military for a long time. They are still serving and they would know, but they were taking it in like a sponge. That is where we are working as much as we can in that area, to be able to read the signs and get help.

Senator FAWCETT: How do you advertise those workshops? Are they things that you do through someone like DCO or the unit command chain?

Mrs MacDonell: No, we just do them on our own. We are just a very small organisation with very limited funds so we just do it on our own bat. We sometimes get VVCS counsellors to come and talk. I do a talk on the families. Last time we had someone who had just transitioned out and who had severe PTSD. He talked about his experience. We have had a policeman who talked about his experience in that as well. I try to get as many service providers in that community together.

Senator FAWCETT: My question was more about how do you contact your audience, and not so much your presenters. Clearly if you have a lot of Defence families who come, how do you contact them? How are they made aware of what you are offering?

Mr MacDonald: What we are finding now, especially with online social networks, are these little community groups. So, Defence family groups popping up on Facebook where they meet and we start getting these networks out. Outside of DCO that is probably the place where the most information is being transferred at the moment. So, for example, when you get posted you can jump on to a Facebook page for the location that you are posting to and ask families in that location where the best place to live is. It is a lot of that sort of social media type place where we are doing the most advertising at the moment.

Senator FAWCETT: You have made a fair point about the fact that only the Army trains and utilises full-time psychology officers. Are you aware of how many of them are actually clinically qualified psychologists as opposed to someone who may have done an undergraduate degree in psychology and then is employed in the psychology corps?

Mr MacDonald: I do not have any statistics on that. I know that the masters program and the Dunt review especially identified that gap. If you go back, the Army used to do the internship and you would just come out as a registered psychologist. I think traditionally they were more an organisational psychologist as opposed to a clinical psychologist.

Senator FAWCETT: My understanding is there is a very low number who are actually clinical?

Mr MacDonald: I may not be correct on this, but I was told that only the clinical psychologists have been sent overseas for the deployments. As you said, they are a very low number and I was told they were very overworked. A friend of mine has a friend who is a captain psychologist and she has been going back and forth a lot.

Senator FAWCETT: You talk further in 5.1 in your submission about the requirement to engage the member's peers, commanders or their families in the post-operational psychological screening process. Is that based on theory? Is that based on feedback that you have had from members? Have members or their families indicated that they would welcome that? I am just trying to understand how you have arrived at that and how it would be enacted if we sought to have that more holistic 360 degree reporting around the psychological state of a member.

Mr MacDonald: Based on theory with the families being important with the recovery process from mental health and generally based on the theory that family members would be the first to see signs and symptoms. In terms of peers and commanders, I cannot speak for all the forces, but we have probably let ourselves down a little bit with not looking out for each other. Again, there is a fear of ruining someone's career.

With deployments, there is an enormous financial incentive to go on these deployments, even if it is multiple deployments that you know you should not be doing. Again, people allow themselves to go through that. I have seen cases where commanders or peers are hesitant to send people, but they had never been on a deployment before. They were sent anyway because of pressure from other people to let them have a go. Those people have issues not related to the deployment. It could be regarded whether they should have gone in the first place.

Mrs MacDonell: Just with the spouses, the families and the partners—in the late 90s I set up support groups for partners of veterans and things like that, and I can tell you that most of those, and the younger ones that I am working with now, would more than welcome the chance to be able to talk to someone about the serving personnel, what is going on at home and difference between deployment and non-deployment and also what is happening after a long period of training when maybe they were not deployed where they have issues as well.

Senator FAWCETT: Are you suggesting that that would perhaps be at a six-month point or something after the person has returned from a deployment or as part of—

Mrs MacDonell: This is the individual differences. This is where I was saying about having someone there as a social worker who knows that area, who knows that routine, who knows the population around there would be best to have. I was talking with someone who was in an accident who had put a car fire out just last week, and then when they put the car fire out they found a body. Now, there were three different reactions. There were three people there. You do not know. It could be that they need support right there and then. It could be that it is maybe six months down the track. It could be that it is a couple of years down the track.

This one-size-fits-all is not a holistic approach. It is not that person centred approach that a lot of people need. I think that is where a lot of people are slipping through the gaps, because, 'We will tick that box. We have done that. We have done that', but it is not further on down the track. Whereas if you put the resources into more localised things where they are given the flexibility to be able to pick up these flags a lot earlier, I think you would have a lot better outcomes in the end.

Senator FAWCETT: This is my last question. Your mission statement says that you are about trying to find funding for research independent of government. One of the things that is frequently raised is that young soldiers

do not want to put their hands up and say they are suffering with physical or mental injuries because they do not want to jeopardise their career or future deployments. Is there any research that you are aware of or are you making any attempts to commission research looking at people who have been diagnosed with a mental health disorder, whether it be PTSD or depression/anxiety, who with treatment have gone back and gone into a high stress situation, whether it be a combat deployment or a civilian equivalent with first responders, police, fire and so on, just to try and provide an evidence base that Defence could then start drawing on to decide if indeed they will redeploy people who have self-identified?

Mrs MacDonell: I am just trying to think of the research that I have read.

Senator FAWCETT: I am happy for you to take that on notice.

Mrs MacDonell: Yes, I will take that on notice, because I cannot think of any off hand where they have gone into the same—are you talking about going back to the same stressful-type situation?

Senator FAWCETT: The same or similar.

Mrs MacDonell: I do know of people in the Army with a Gold Card who have been diagnosed with PTSD being sent back over to Afghanistan and Iraq, but they were high-ranking officers.

Senator WHISH-WILSON: Did one of them write a book?

Senator LAMBIE: Mr MacDonald, in your experience is it or has it been Australian Defence Force policy to allow serving members to take antipsychotic medication and then go armed beyond the wire? Are you still serving? I understand if you want to take that on notice and not answer that question here. I understand you are in a predicament.

Mr MacDonald: I will take it on notice.

Senator LAMBIE: I wanted to put a question to Mrs MacDonell. You say:

> The systems and processes require boxes ticked and sometimes reticked. There even appears to be silos within silos where a group in one department will misplace and not tick the correct box with paperwork and the other group within the same department cannot move any further with a claim or complaint or other required process.

Are you describing a dysfunctional DVA? Are you describing a dysfunction when it comes to Veterans' Affairs?

Mrs MacDonell: I am describing a dysfunctional system. I prefer to talk in systems. It would be safer that way. It is a system, because I have met some people in the department who are really caring and want to do the right thing. To give you an example of that, apparently depending on what legislation you are under, VEA, SRCA or MRCA, then your papers go to different areas—Brisbane, Sydney and Adelaide, I believe. I also help a pension officer. I have done a pension course, but I do not take it on because it is too much responsibility with everything else, but I do help them with a lot of the medical things that are going on. And basically things have been apparently held up because they are in different areas, and because they are covered under what might be under the two or three legislations, they are all in different areas under different people. I kind of believe that the case managed approach is far better than this dysfunctional silos. That is what I was thinking.

Senator LAMBIE: Would the automatic issue of a Gold Card for those who have served in war-like or war conditions solve the problems of bureaucrats losing the paperwork?

Mrs MacDonell: As a personal thing, I have an issue with automatically giving people a Gold Card. Having spoken with lots of veterans—and to be honest I have not talked to a lot of current serving people about this as the issue has never come up—it would devalue. The people who already have Gold Cards and who have been injured, wounded or have other disabilities, to them it would devalue what they have done in their service if everyone was to automatically get one.

Senator LAMBIE: So, it devalues their fight for their right to be given a card for service and put their life on the line?

Mrs MacDonell: What I believe is maybe not a Gold Card but a White Card so that from the time that they have that card, if they have mental health problems they can access services straight away while everything is going on. That is the big issue. That is the gap. From the time that they want to—

Senator LAMBIE: You cannot do that on a White Card though. With a White Card you can only do it for the condition that has been accepted. A Gold Card means all of your healthcare is fully covered. That is what I am asking you.

Mrs MacDonell: Maybe a different coloured card. I am just going on what I have been told from other veterans; that it would devalue what they have gone through.

Senator LAMBIE: Which veterans? Are they Vietnam veterans or veterans from Iran and Iraq?

Mrs MacDonell: Vietnam and the first Gulf War, yes. I am just saying that this is what I have been told, the feedback. There was a push a long time ago for the wives of people on a TPI to have a Gold Card, and just as a personal issue I have a thing about that. I think that wives should not have a Gold Card as long as there are veterans out there without a Gold Card, because I think they should have something. If they are being transitioned out they should have some kind of ID, maybe not a Gold Card but something like that, to say, 'I can get my things treated straightaway' while everything else is being sorted out. A lot of things may be sorted out by the time they finally leave and they are discharged for good.

Senator LAMBIE: I would have to say that there are men and women out there fighting to get psychological help. They have been in these war zones and they are actually losing their lives.

Mrs MacDonell: I agree with you totally that they should not have to do that, but because I represent lots in the community—the thing with the Gold Card is this Gold Card seems to be this big standard. You know what? A lot of people get that Gold Card and think, 'I'm right now', and it does not work. Six months or 12 months down the track they have found that that Gold Card has not fixed them, because they see that as the ultimate goal.

Senator LAMBIE: Do you not think that they have got to that point because it has taken four or five years for them to fight for that Gold Card? Had they been given that Gold Card initially to start with without the fight, their psychological issues might not have worsened under the bureaucratic system? That is what I am asking you.

CHAIR: Senator Lambie, Mrs MacDonell has answered the question three times that I recall. Perhaps if you are pausing there Senator Whish-Wilson could proceed?

Senator LAMBIE: I do have a couple of questions actually on whistle-blowers within Veterans' Affairs. Do you know of any reason why those that are working under Veterans' Affairs as public servants are not coming up to blow the whistle on what is going on under Veterans' Affairs?

Mrs MacDonell: I do not know anything about whistle-blowers. I have had a personal experience, a very tragic personal experience, with someone who was a blind caller to DVA who they acted on and then that resulted in, about two years later, a suicide, but I do not have any idea about the whistle-blowers within DVA.

Senator LAMBIE: Do you believe that the dysfunction in DVA would be a duty of care for those workers to come forward and alert the government to what is going on? Do you believe that is their duty of care as a government worker?

Mrs MacDonell: I work in the health—

CHAIR: There are loaded assertions in that question, which you need to think about. carefully

Mrs MacDonell: Yes. I was just going to say that I work in the health system as well, and I believe there is a duty of care of all institutions towards their workers.

Senator LAMBIE: Do you believe that Veterans' Affairs is failing in their duty of care when it comes to the psychological injuries it is compounding on our veterans?

Mrs MacDonell: I would have to take that on a case-by-case basis, because I know that some are good and some have worked.

Senator LAMBIE: I have no further questions.

Senator WHISH-WILSON: I have two very quick questions. In your submission you make recommendations for an accurate register of suicides of serving and former service personnel to be published. How far are we away from seeing something like that?

Mrs MacDonell: I was actually amazed when I found about 12 or 18 months ago that they actually did not keep records—this is with the silos—and that once they left Defence and then it went to DVA that they were not keeping the actual records. I know that there is someone online who has met with DVA that is starting a record, but I do not think that is accurate enough and I think Defence members deserve better than that.

Senator WHISH-WILSON: You are suggesting be it DVA or be it the Department of Defence or some other government that register?

Mrs MacDonell: Yes.

Senator WHISH-WILSON: That clearly explains when—

Mrs MacDonell: Yes. They could do that with the ABS and follow up with that. It would just take that communication right through.

Senator WHISH-WILSON: Lastly, I was having a quick chat to Mr Bale from Soldier On a little bit earlier, who said that one thing he did not go into in his evidence was that PTSD and other mental illnesses, the kinds of things we have been discussing, tend to be taken more seriously by the Army, he feels, than perhaps by the Air

Force and the Navy. Do you agree with that in relation to your experience with early prevention and other things we have been discussing? We have heard about a full-time psychologist as one example, but perhaps do you—

Mr MacDonald: The issue in answering that is that one of the unique things of Defence is that it is three separate forces who have similarities and also vast differences not just in the jobs they do but the cultures and how they deal with things. On top of that we have vast differences between areas. Townsville is different from RAAF Base Williamtown and different from the Randwick Barracks. On top of that we have vast differences between units and how COs run things. You will see with the Army, because they have had on-ground troops in firefights historically for a very long time, that they may treat it differently. Again, the Air Force is fairly new, but I could not say if there is a vast difference between how the three of us deal with post-traumatic stress disorder.

Senator WHISH-WILSON: It just interests me that obviously the Navy, with some of their operations now, are seeing people drown at sea and these things could be quite stressful. I am just wondering how far they have gone down that road.

Mr MacDonald: I do not have the answer to that.

Mrs MacDonell: I do know of a girl that I work with whose husband was with the Border Patrol up the top. We were talking and chatting and they said they had a lot of issues with that kind of thing, but how they treated it, I do not know. She was doing her clinical psyche.

Senator WHISH-WILSON: I might ask the Department of Defence when we get to it.

CHAIR: Thank you very much for your evidence here today. If you could remain behind for a few moments in case the secretariat needs to clarify any matters with you. If you have taken questions on notice you have a reasonable amount of time to answer them. Thank you very much.

FORBES, Professor David, Director, Phoenix Australia Centre for Posttraumatic Mental Health

PHELPS, Dr Andrea, Deputy Director, Phoenix Australia Centre for Posttraumatic Mental Health

[12:21]

CHAIR: We now welcome Pheonix Australia Centre for Posttraumatic Mental Health. Just before we go to the opening statement, with Hansard's concurrence, we will try to finish all of your evidence prior to the lunchbreak, otherwise we will have to get you back after it. Would either of you like to make a brief opening statement?

Prof. Forbes: I would. Thank you very much. Phoenix Australia is associated with the Department of Psychiatry at Melbourne University. Our mission is around supporting individuals, organisations and communities respond from the psychological effects of trauma. As seen in our submission, we have a fairly longstanding track record of working with the Department of Veterans' Affairs and the Department of Defence in relation to mental health. Some of those initiatives have included the development of the Australian guidelines for the treatment of post-traumatic stress disorder endorsed by the NHMRC and the professional colleges, support to Defence and implementation of mental health screening and post-trauma responses, randomised control trials for the treatment of military PTSD, and the development of training programs in military mental health for general practitioners and clinicians across the community together with the College of GPs and other health professional organisations, and also the monitoring and accreditation of PTSD treatment programs for veterans. We also receive some core funding from the Department of Veterans' Affairs for general advice on mental health.

In our view, the mental health services for past and present members of the Defence Force have improved considerably in the last 10 years. In our submission we mentioned many areas where there has been considerable movement. We also identify a range of areas where we think there is considerable room to improve significantly further. Some of the areas where we are starting to see movement include things like reductions in stigma, mental health screening and increasing access to mental health care, both face to face and eHealth. In all of those areas we are starting to make some inroads, but there is considerable requirement to move much further on those into the future.

Just in this brief opening address I was hoping to highlight two further points. One is the area of improving the space around transition from current serving to civilian life, and the second is about improving outcomes, particularly focusing on early outcomes in terms of early intervention and particularly also treatment of complex mental health problems for veterans, and along with that about integration of the service system not only across the levels of care around the clinical providers but also integration around vocational rehabilitation, families, ex-service agencies and community supports.

In terms of improving the process of transition, there are three key parts that we wanted to mention. One is the need to remove the disconnections that occur within the service systems. Currently there is the lack of continuity of care of serving member discharges. They need to terminate from their current provider and re-engage with a new health provider. It does run the risk of interrupting one treatment and running the risk of the serving member falling through the cracks. We would encourage DVA and Defence to consider extending the period that the Defence health services might be available to the serving member for a period, say, of one to two years post-discharge to minimise that likelihood or, alternatively, to consider the integration across the service systems so we can have one health service system.

The second is about improving ongoing health surveillance. What I have just said before applies for those who have an identified mental health problem. What we also know—and we heard many presentations earlier today as well—is that while a serving member might discharge feeling well and healthy, the challenges about reintegration into civilian life can lead to a range of issues starting to emerge. So, building on some of the current initiatives around how you build ongoing surveillance, how you stay in touch with the connection of ex-serving members discharging from Defence over the course of those next few years to ensure that there is a maintaining of that network and maintaining of the communication and contact to be able to quickly identify those that are developing problems as they try to reintegrate into civilian society.

The third area is around what we might call deprograming—training for civilian life. We appreciate that an enormous effort is made to ensure that our serving members are well trained in skills essential for survival in combat. So, threat detection, rapid response, intense unit cohesion, high expectations of others, skills that are critical for effectively functioning within a combat related environment or a threat environment. But ironically some of these same attributes can make life difficult in terms of re-engaging into civilian society, which operates in many respects in different ways. What we recommend is a greater attention to strategies designed to deprogram

discharging veterans or discharging serving members to provide them with the life and personal skills that they might need to adjust to civilian life.

The next main issue is really improving outcomes for current and ex-serving personnel with mental health problems. There are three key points here. First, we need to increase the uptake of evidence based treatments. Unfortunately many practitioners out in the community still do not use evidence based treatments, even more so for veterans with complex and serious mental health problems. Ineffective treatments mean the veterans continue to stay unwell as well as making longer wait times for new veterans coming into the system.

Secondly, as we heard also earlier today, there is fragmentation across elements of the service system, between primary care, so GPs, community care and hospital based care—so fragmentation along the lines of clinical services, but as well as a lack of integration with broader rehabilitation providers, vocational rehabilitation providers and general community support and advocacy groups. Thirdly, we need to improve treatment options.

CHAIR: Professor Forbes, I thought you said you had two issues.

Prof. Forbes: Two issues. The third point in relation to the second issue. Chair, I will finishing very shortly.

The third point under this is that the reality is even with the best treatments a third to a half of veterans or serving members with serious mental health problems improve adequately, even with the best treatments, so it is critical that we continue to move the field forward. It is the same here as it is with our colleagues internationally. The reality is the current best treatments are limited with what they can get. We need to continue to improve how best to match serving members to treatments, how we can build on existing treatments to make them more effective, how we can identify underlying mechanisms, biological and psychological, to address those to improve outcomes and also how to improve treatments and develop new treatments.

Our centre, to address all of the above problems, is recommending two key functions: a practitioner advice service to provide guidance to practitioners across the country who are dealing with veterans with serious mental health problems, PTSD, depression, anger, aggression, substance use, suicidality, to help practitioners guide it in terms of applications of best practice treatments; and, alongside that, a treatment research centre that together with a range of collaborators across the country moves the field forward in terms of improving treatment effectiveness so that our veterans, once they enter care, get better outcomes. Thank you very much.

Senator LAMBIE: In your experience is it or has it been the Australian Defence policy to allow serving members to take any psychotic medication and go armed beyond the wire?

Prof. Forbes: I am not sure that I could answer that question. You would probably need to speak to Defence about that, but I believe not.

Senator LAMBIE: Will the government's decision to increase deployment times from six to eight months increase the likelihood of PTSD for veterans?

Dr Phelps: I do not think that there is any empirical evidence about that, but we do know that when people are exposed to prolonged and repeated trauma it does increase their risk of developing mental health problems. So, on the face of it, it is probably reasonable to think that it will potentially increase the risk, but I do not think we have any evidence about that and, importantly, it is not so much the deployment itself but what happens to people when they are on deployment that is important. It is really about the extent of trauma exposure specifically that you would be wanting to be concerned about.

Senator LAMBIE: So, when compared with previous conflicts like Malaysia, Indonesia and Vietnam, is it fair to say that our younger veterans over the past 15 years have spent more time serving in war-like or war zones?

Prof. Forbes: I guess the key point, as Dr Phelps has mentioned, is that the risk factor around mental health is around trauma exposure and exposure to adverse events, so the more adverse events the person is exposed to the increased risk there is of significant health problems. There is not a one-to-one relationship between deployment and traumatic exposure, but where those events occur that increases. The more events the greater risk of mental health problems.

Senator LAMBIE: So, as a part of our responsibility of duty of care do you think that there should be a maximum number of years that our Australian Defence Force personnel should spend in war-like or war conditions?

Dr Phelps: It is hugely variable for individuals. We really do not have the science to be able to say a certain number of exposures is too many for people. Some people will go through their entire career without any adverse mental health impacts and other people will be affected after one event, so it is really not as simple as to say that there is a number that we can give it to say this is ideal. It is very much an individual thing. The issue is much

more about ongoing monitoring of people's wellbeing so that if there are signs that someone is starting to not cope or starting to struggle in some way that is picked up.

Senator LAMBIE: So nobody has the science on this? Is that what you are telling me, Dr Phelps?

Dr Phelps: It is.

Senator LAMBIE: Around the world there is no scientific evidence on this at all?

Dr Phelps: There is no science that tells us a certain number of traumatic exposures is going to be too many. For some people one traumatic exposure is enough to cause problems. For other people they can be exposed throughout their entire career, whether that is in the military, police, fire or ambulance, and not have adverse mental health effects. There is a lot of research, a lot of science that looks at risk and protective factors, but we do not have an absolute number of events that we know are going to be causing harm.

Senator LAMBIE: So, we have no current studies going on in Australia on what we are doing to our men and women who have done four or five years in a war zone? Is that what you are telling me, that we have no studies on that to tell us what is happening to those men and women?

Dr Phelps: I believe that the ADF Mental Health Prevalence and Wellbeing Study will be looking at that and also the Longitudinal Resilience Study that Professor Forbes would be able to speak to. There are studies that are happening, but we do not have the answers yet.

Prof. Forbes: There is a range of prevalence studies that have occurred, as in our submission, from cohort to cohort, with cohorts that have experienced deployments. There is the ADF Mental Health Prevalence and Wellbeing Study and there is the current Mental Health and Wellbeing Transition Study that is looking to examine members who have transitioned out of Defence over the past five years. All of those studies are pointing to similar findings, which is that trajectories and influences of impacts of traumatic events vary from person to person, but overall those studies, the studies we have done here in Australia and the studies done by our colleagues overseas point to one of the rules of thumb, which is the more events that happen to you the greater the risk.

As Dr Phelps mentioned, it varies from individual to individual. Having said that, the critical part is being able to embed within health service systems and within high-risk organisations, whether they be Defence, police or other emergency service organisations, where there is a high risk of exposure by virtue of the job, embedding in those systems trauma management frameworks to improve identification, support and early intervention and early detection where there are problems, because there is so much individual variability.

CHAIR: Just on that point, if I could just try to understand this. We have heard evidence this morning that people have spent as much time in a war zone as people spent in the entire Second World War. Are we hearing that there is no evaluation pre deployment and no test and check as people are redeployed and redeployed? Surely there must be an evaluation before they go?

Prof. Forbes: Yes.

CHAIR: And when they come back and then if they are going again? There must be an incremental checking system in place?

Prof. Forbes: Yes. That is exactly what we are suggesting there is.

CHAIR: It is in place?

Dr Phelps: Yes.

Prof. Forbes: Yes. What I was referring to is that there is no scientific evidence to say X figure of deployments or X period on deployment is the cut point for when it is—

CHAIR: There is clearly in place an evaluation system of deployed, returned, check and balance, and then deployed, returned, check and balance?

Prof. Forbes: Correct. That is right.

Senator LAMBIE: So, what are the results from that? I am yet to see those results. Where are those results from, those studies?

Prof. Forbes: They are clinical processes and practices. They are part of a trauma management framework and an exposure management framework that occurs within mental health within Defence. They are not research studies as such. They are trauma management practices around how to identify risk, how to intervene and how to provide services and support for those who might then be at potential risk down the track. Those practices are akin to the kind of practices we see in other high-risk emergency service organisations.

Senator LAMBIE: So, what you are saying is that it is acceptable that they could serve 11 deployments or greater? Is that acceptable?

Senator WHISH-WILSON: That is not what they are saying.

Prof. Forbes: No, that is not what I am saying. What I am saying is that the more deployments, the more risk of exposures, the higher the risk gets. I am saying that. What I am saying is that the critical part then is to embed trauma management frameworks to help to support and identify early on a continued basis risks around mental health and provide a culture whereby people are able to self-identify or be identified by others and the system is able to offer intervention. Certainly if someone was talking about 11 deployments you would be having them on very close surveillance in terms of monitoring, but it is not as though we have evidence around how many deployments is too many deployments. Critical, though, is that you have systems that are able to identify people as they multiply deploy. I think a critical issue that is raised in the future is, does having some research there answer this question of how much is too much? I think it is a very valid and important area of future research that I believe existing research projects will be looking at as part of the analyses.

Senator LAMBIE: They probably should have been looking at them quite some time ago. So, what is the maximum number accepted by our commanders that these people can do? We just keep sending them over and over and over, do we, and doing more and more damage?

Dr Phelps: We are not necessarily doing damage. That is the point. For some people they can have multiple deployments without having mental health harm done to them.

Senator LAMBIE: Do you have the statistics of that? We have only got to look at our Vietnam veterans with who has done one year, who has done two and who is damaged and more damaged. So, if you do not have those statistics I suggest you probably need to go and have a look at them. It is like your submission. You are reporting the ADF and the DVA, basing your statements on what exactly and where is your KPI to support these statements that you are making? Where are your key performance indicators to say that they are always successful? I have not yet seen any of this.

CHAIR: I think the witnesses have answered to the best of their professional ability. If they do not have the answers to the questions it is probably beyond their control. I think it would be a good point there to move to Senator Whish-Wilson.

Senator WHISH-WILSON: Dr Phelps, in relation to your answer to Senator Lambie's question, is there an increased risk of multiple deployments and the trauma that is potentially associated with it further down the track? I understand you may say that now that it is a very individual thing, like PTSD and other illnesses, but is there an increased risk further down the track in 15 to 20 years time from these kinds of multiple deployments?

Dr Phelps: So the cumulative impact?

Senator WHISH-WILSON: The cumulative impact, yes.

Dr Phelps: Yes, there is, and again not for everyone.

Senator WHISH-WILSON: It is not for everyone.

Dr Phelps: But certainly the more exposures—and in the military context it is not usually just one exposure, it's repeated exposures over a period of years—and so, yes, there is an increased risk with repeated exposures.

Senator WHISH-WILSON: I just wanted to note that our good committee staff did provide us with some information and what they told us was that there was conflicting evidence about deployments per se. They said that internationally—and I can give you this afterwards—studies in the United Kingdom and Canada showed there was direct correlations between length of deployment, but the Australian study, the 2010 MHPWS, indicated that there was no link, so it seems as though, at least from our internal documents that we have been given, there is conflicting evidence out there on this.

Dr Phelps: I think as Professor Forbes pointed out earlier, it is not the deployment as such but it is what happens to you when you are on deployment. I think even within the Australian context that the more exposure people have to trauma on deployment that there is that relationship.

Senator WHISH-WILSON: So, you were set up essentially by DVA and the Department of Defence. Do you do other PTSD work outside of the military? Do you do it for emergency services and for police as well?

Prof. Forbes: Yes.

Dr Phelps: We do.

Senator WHISH-WILSON: I am just interested in the differences in treatment, if any, and the at risk percentages of emergency workers and police to these kinds of illnesses. Are they different to military service related illnesses?

Dr Phelps: No, is the short answer. To the extent that the exposures are similar, the sorts of mental health impacts that you see are also similar. Police, fire and ambulance people tend to have the cumulative exposure as well. Some of the issues that we see in any of those organisations where the unit cohesion and morale within units can be important buffering effects for the impact of trauma; we see that in emergency services as well. We see that people when they are in service can often hold it together quite well and not put their hand up to say that they have got a problem, but when people leave service that is often the time when you get a spike.

Senator WHISH-WILSON: Has it been better recognised and better dealt with? Are there early prevention programs in place for those kinds of at-risk categories versus the military that we are dealing with here? I know it is a very general question, but is it well established and well accepted?

Dr Phelps: In general terms, the military would be more advanced than other organisations.

Senator WHISH-WILSON: Would be more what?

Dr Phelps: More advanced.

Senator WHISH-WILSON: That actually correlates with some evidence we heard in Canberra as well that suggested that the military was more advanced.

Prof. Forbes: Yes, and in fact a range of the emergency service organisations look to a lot of the military services and symptoms for guidance not only in terms of being able to monitor and support people to early identify but some of the work that the military has done around trying to build resilience in advance of exposure, in advance of deployment, is of great interest to the emergency services also.

Senator WHISH-WILSON: Including the police force?

Prof. Forbes: Including the police force, yes. Can I just respond to what Dr Phelps said as well, which is the issue about the cumulative risk and the fact, as you have mentioned, that the risk can continue kind of post-discharge. Coming back to our original point for us, the critical bit is when you are in service, in uniform and you are supported by the unit cohesion and you are supported by a very structured environment, the identity around your role and your function, a big risk happens in terms of this cumulative exposure where things may have been held together and once you take off the uniform you lose the structure, you lose the identity and then you meet the struggles of reintegration into civilian society. For us, the reason we started with that first issue about transition, is we do see that as a significant risk period in the first two or three years afterwards with due risk increasing mental health problems.

Senator WHISH-WILSON: Is it correct that some PTSD symptoms, as an example, are actually beneficial to military personnel in that kind of environment where they need the stress and that the problem is that when they are removed from that environment they are—

Prof. Forbes: That is exactly right. When you are actually in that environment you want to be hyper alert. You want to be hypervigilant. You want to be very focused on details. The implication of those when you are outside of that environment, particularly once you are then back into a civilian environment, can actually lead to an accumulated life of stress and then suffering for you and for the family around you.

Senator WHISH-WILSON: I am sorry, but we are running out of time. I have a lot more questions. I asked the RSL about evidence based treatments, because they included it in their submission as well. Is there a significant body of evidence here—pardon the pun—on what is evidence based versus non and why do we have this situation where we have these kinds of treatments that you do not support or you do not think are necessarily effectively in place?

Prof. Forbes: Perhaps to recast that a fraction. We do have treatments that are effective. The reality, though, is that whether there is a strong evidence base, Australian and international, military and non-military, so a strong evidence base. The reality, unfortunately, is that those treatments do not work for everybody. There is about a third who do very well and, for example, if we are talking about PTSD, that no longer have PTSD. There is about a third who get a lot better but still have significant problems and symptoms and there is a third for whom are failing to respond or unable to benefit from those treatments and these treatments are not touching the sides.

At the moment that is where we are. We have treatments that are effective but they are not effective for everyone and a critical phase for the next five to 10 years is that we focus on improving outcomes of treatment. It is not good enough that half to two-thirds of veterans and military members who have very serious mental health problems are not gaining enough benefit from these treatments.

What we have heard earlier today is that PTSD, associated with depression, substance use, aggression, suicidality and family breakdown—these are very serious accumulations of problems and at the moment we do not have the treatments to adequately treat that effectively for everyone. That is the key mission for an organisation like ours and for our collaborators across the country of how to improve and get better outcomes for those treatments.

It is important to say that what we are doing here in Australia is as good as what is going on around the world. This is a struggle we all have. The treatments have moved a long way forward but we need to get better outcomes from treatments and improvements in treatments.

CHAIR: Just on that, we need to be better at preventing them, don't we?

Prof. Forbes: Definitely.

CHAIR: That goes exactly to Senator Lambie's point about whether we need to wait 10 years to find out that 11 deployments was too many.

Prof. Forbes: Absolutely. We need to be focusing on prevention, early intervention and treatment for serious mental health problems. In answer to the question before—and I suspect that perhaps the discussion was not quite along consistent lines—absolutely there is the issue, as we were saying, about increasing risk with increasing exposure and there has to be a lot of attention paid to that. The research that is being done is looking closely at what are the accumulated risks, to the point we can answer the question: is there a cut-off? The issue at the moment is that we and our colleagues around the world do not know what that is. We know what the risks are so we pay close attention to those risks and service systems that address those risks, but you are absolutely right, it is critical that we can confidently answer that question going forward from a prevention perspective.

Senator WHISH-WILSON: In relation to articles of interest that have been in the media recently on PTSD around the use of animals like dogs and training parrots and gardening as well, are these taken as being serious? Are these being investigated as serious treatments for PTSD?

Dr Phelps: They tend to be seen more as adjunctive help/assistance/intervention. The evidence based treatment for PTSD is very much about helping people to confront their memories of the trauma that they have been exposed to and doing that in a very systematic and detailed way, and that is with the idea of reducing the actual symptoms. But a lot of the interventions that we hear about are geared towards helping people to reconnect socially and emotionally with other people, which are all really important elements of what happens when someone develops a mental health problem; they do tend to become isolated and cut off. So, all of these things are very helpful adjuncts but are unlikely to be considered first-line treatments for mental health disorders.

Senator FAWCETT: In the work that you have done with police forces and other first responders or international studies that you have looked at is there any evidence to suggest that someone who has been treated for PTSD can return to an environment such as an operational posting?

Prof. Forbes: The answer is, no, we do not know. There is lots of anecdotal evidence and there are lots of reports from within those organisations about what they have observed. You had asked also the same question earlier and I thought to myself that is a critical question to be asking. The answer is that we do not know at the moment. We do believe strongly, and we all see our clinical work and we see it within organisations, that people can improve such that they can return to work and function well at work, but we need to apply some science to that to get better answers about what rates, what are the risk factors and what are the factors that mitigate a successful return to work and an unsuccessful return to work, and what does that look like down the track. Even if they are functioning okay now, does that have cumulative effects for later on?

Senator FAWCETT: So, is there any longitudinal work underway in looking at that at the moment?

Prof. Forbes: There is a range of studies that are occurring whereby current engagement in the work is built in. We do not have the answers to that just yet, but they are critical questions.

Senator FAWCETT: Are you providing any guidance to either the police forces or in this case Defence around how they can still have an appropriate duty of care for the individual but start down the track of saying, 'Yes, we will let this person who has self-identified having problems, they're receiving care, and we will put them back into that situation'? Are you providing them with the sort of basis by which they can do that whilst still maintaining an appropriate duty of care? I am conscious that if people are not sending folk back, then there is no evidence that you can assess but at the same time we cannot send people back if we are not sure that it is not going to harm them further.

Dr Phelps: From a clinical point of view as opposed to a research point of view, I think that that is happening. Anecdotally we have evidence that people can do that. Our advice would generally be that it is a careful

assessment. First of all, they need to be successfully treated. You would not want to send someone back when they still had an active PTSD, for instance, but if their PTSD is resolved you look at what the risk factors are in going back in. It is a collaborative process between the patient and the clinician, I think, and the workplace to work that out on a case-by-case basis. You would probably do it in a gradual way. So, you would not throw someone in at the deep end, but you would put the toe in the water to see how resilient they were and then build it up from there.

Senator FAWCETT: I will rush through these, because I am conscious that the chair wants to finish up very soon. You said some really positive things about Defence and DVA, and I appreciate that, acknowledging what they have done. You talk about their commitment to training with a view to increasing mental health competencies within the Defence community. We had a discussion earlier on about employment of perhaps undergraduates in the psychology stream and calling them psychologists versus having clinically qualified psychologists. Do you have an opinion on the efficacy of employing, for example, an undergraduate or an organisational psych as opposed to someone who the country has invested that clinical level of training in, and is that where we should be aiming resources?

Prof. Forbes: I think certainly if the person is providing a clinical role it is very important for them to have clinical training.

Senator FAWCETT: Are there other career streams such as therapy, counselling, social workers and so on who can provide part of the spectrum within that and should that be 90 per cent with 10 per cent clinical psychologists or should we be aiming for the majority of the workforce at that clinical level?

Prof. Forbes: It is more about competencies than it is about which profession you come from. There is good evidence now for training multidisciplinary workforces in specific clinical competencies, and the outcomes for that are good and strong. So, the critical part is, yes, there is room for a spectrum, but being crystal clear about what people are being asked to do, ensuring that they have the competencies to do so and, if not, ensuring that they are trained up to be able to deliver whatever intervention it is.

Senator FAWCETT: Do organisations such as yours ever get asked to come and provide independent peer review of the workforce structure in the ADF so that rather than them making a self-assessment that this is fine, that they have somebody independent come in and look at the roles and look at the qualifications and go, 'Yes, you've got it right' or 'No, we need more investment'?

Prof. Forbes: We have not been asked to have that role. It sounds like a kind of competency audit in some respects.

Senator FAWCETT: Yes. That is exactly what I am suggesting.

Prof. Forbes: Yes.

Senator FAWCETT: The last part—you talk about the fact that there is a third of people that current treatments are not supporting. I notice Bill Nash, the head psychiatrist for the US Marine Corps, is doing work in the area of moral injury, and we have a witness later this afternoon talking about that. Is that a different stream of approach to treatment or is it just a different label for something that is already part of the mainstream? Could you give us a quick two minutes on that?

Dr Phelps: It is being tested in the United States as a supplementary to the PTSD treatment with the idea that the core PTSD treatment is based on a fear mechanism; that someone has developed PTSD because of being overwhelmed with fear. Whereas moral injury is more about those circumstances where people have been confronted with situations where they have seen and done things that have transgressed their moral values. So, at the moment it is being considered as a sort of adjunctive to core PTSD treatment for those people who have what they would consider a moral injurious event that is alongside their PTSD. So, it is one of the things that holds promise for improving the rates of success with veterans with PTSD, because it is addressing some of the other elements of trauma that veterans in particular are exposed to.

Senator FAWCETT: Thank you.

CHAIR: We thank you for your evidence here today. If you could just remain behind for a few moments in case the secretariat needs to clarify any matters with you. If you have taken questions on notice you have a reasonable amount of time to answer them. We will now suspend for lunch and resume at 1.40.

Committee suspended from 12:57 to 13:42

ARVANITIS, Mr Nick, Head of Workplace Research and Resources, beyondblue

CARBONE, Dr Stephen, Policy, Research and Evaluation Leader, beyondblue

CHAIR: We will now resume the hearing and I welcome representatives from beyondblue. Do you wish to make a brief opening statement before we go to questions?

Dr Carbone: Yes. First of all, I would like to thank you for the opportunity to present to the committee. As you may know, beyondblue is an independent organisation funded through the Commonwealth government and each state and territory government, as well as through donations. Our focus is on anxiety, depression and suicide prevention.

beyondblue started in 2000 and initially focused on raising awareness about depression and then moved towards including a focus on anxiety conditions and, more recently, suicide prevention. Our main interest is twofold, to work towards protecting the mental health of people by trying to find ways to prevent anxiety, depression and suicide, but also to support people who have become unwell. That is based on the knowledge that these conditions are extremely common in the community and that they carry a considerable burden of distress and potential for disability and obviously increased risk for suicide.

Despite the prevalence, we also know, unfortunately, that a lot of people do not seek help for these conditions or are not receiving the best evidence based care, so what we are looking to do is to look at the barriers to that to try to address that, whether that is raising awareness and improving people's understanding of these conditions so they can self-recognise or recognise these conditions in others, trying to break down the stigma, which is one of the biggest barriers to help seeking and also in terms of recovery, and trying to encourage or promote people to see health seeking as responsible, the norm and the reasonable thing to do.

We are also trialling different pathways for people so that we extend the breadth of the service systems so that there are different options for people depending on the severity of their condition, because these conditions are quite heterogeneous. You can see some people with fairly mild forms of depression and certain anxiety conditions right through to people with very complex, chronic health care conditions, as we have already heard today, and what you need is a bit of a tailored approach. You need to be able to find the right treatment for that person's individual circumstances. Some people might manage well by themselves; some people need very specialist sort of care, for example, with PTSD. In the work that we do we work across settings and we are finding that we are doing a lot of work in schools and in workplaces.

Now, our interest in coming here is partly because we are trying to promote mentally healthy workplaces, though the Defence Forces are a workplace but they are obviously a unique workplace. They have certain characteristics and risks within that workplace that are different from many others, although possibly some overlap with emergency services, as we have heard. However, we think some of the principles that we have found that apply to the general population, that work for other people with depression or anxiety conditions, may also have some relevance to workplaces and even unique in particular workplaces.

What we are trying to move towards in our work is to work out ways, in terms of the treatment, how you can maximise the number of people that are going to get the effective help. If everyone came forward who needed assistance the current workforce possibly would not be sufficient, so there has to be some innovation. There has to be some way of finding other ways to assist people with these conditions than we currently have, whether that is through step care approaches or technology based approaches.

In the workplace I think all three things are required. There needs to be a focus on understanding the risk and protective factors for that specific workplace. Some will be generic. Some will be unique. We need to work towards reducing those risk factors and promoting the protective factors. That is looking at workers as individuals. It is looking at the job that they do and the characteristics of the job. It is around the leadership group and management of people that support workers to do their work and it is also about the overarching culture of the organisation. There are some things we know that can promote good, healthy workplace practices and some things that get in the way and actually increase the risk, so within the Defence Force, as we said, some things are possibly similar to other workplaces and some things are obviously entirely unique.

CHAIR: Dr Carbone, are you a psychiatrist, a psychologist or a general practitioner?

Dr Carbone: My background is in medicine. I have worked as a general practitioner and recently moved into the public health field in terms of mental health promotion.

CHAIR: I am just trying to play the devil's advocate in some respects. What makes Defence people presenting with post-traumatic stress or depression different in a clinical sense than someone beyondblue may come into contact with as being a mine worker or a policeman? Why do they need special—

Dr Carbone: I think PTSD is a particular type of mental health condition that requires certain specialised skills, but with depression and other anxiety conditions which are quite prevalent within the armed forces, as they are within the broader community, there is a lot of similarities. There does not need to be a particularly different approach other than I suppose with PTSD as a standalone condition.

CHAIR: So, is it too simplistic to say that there is not a need for a specialist treatment process for ex-service personnel?

Dr Carbone: I think that is simplistic. I think you want to be able to provide the services both to the community as easily as possible, but some of the mainstream community services, if they were attuned to the unique experiences of this particular population, could be a back-up and could be a support.

CHAIR: But some of the evidence that we are getting is that people are hesitant to disclose any symptoms because it might interfere with their claim, their career or their peer standing. That is no different to the community anywhere, I presume, in beyondblue's expectations.

Dr Carbone: Absolutely. It is stigma and fear of disclosure. Fear of disclosure within the workplace is one of the major barriers to seeking help. People are worried. 'What is this going to mean for my job?' Whether you are a bank manager or anyone in any industry, that is a common concern. That is what I mean, I think there are a lot of similarities across the whole population. There are some unique characteristics here but a lot that is very similar to what any person in Australia with depression, any person in Australia with an anxiety disorder, any person in Australia with PTSD might be experiencing as well.

CHAIR: And someone in a regional police force, a state police force or the Federal Police would potentially have the same issues?

Dr Carbone: Absolutely. We have seen by reviews of the mental health system the similarities to what was discussed this morning. You need the services there. You need them to be coordinated and continuous. You need people to have follow through. People need that sense of confidentiality that they are going to be able to disclose without repercussions. These are common concerns with people with mental health conditions.

Senator FAWCETT: In your submission you talk about e-mental health services and you talk about the application of broader community. One of the topics that came up again and again today is about how families and indeed servicemen should access services very early on. Do you have any studies that show the efficacy of essentially self-help e-based services or, secondly, services delivered by via video link with a practitioner?

Dr Carbone: The area of e-mental health has taken the approaches that we use in face-to-face clinical settings, predominantly types of therapy based on cognitive behaviour therapy, and trying to apply them to a sort of internet environment. There are different set-ups. Some are completely self-administered, so you can log in and go through the modules and learn the techniques that a therapist might teach you all by yourself. Others are backed up by a telephone counselling service so that you have both contact with a counsellor as well as working your way through the mental health program on your own.

So, there is quite a lot of evidence of efficacy for both, possibly a little bit more for the counsellor assisted approach, but even the standalone, do-it-yourself sort of approach in efficacy trials, so in controlled experiments, lends itself to improving outcomes. Part of the problem is uptake, so not everyone wants to go down that path, and another part of the problem is sticking with it, so people might start but not necessarily complete the whole program. They definitely show great promise in being able to expand what you can provide to more people, particularly with the more traditional sort of depression and anxiety conditions. I am not so familiar with e-mental health programs for PTSD. Other people might be able to comment on that.

Senator FAWCETT: We have had some submissions encouraging us to look at increasing resourcing at individual bases, to have a social worker or a community worker with the DCO. Do you think that this system of having a counsellor assisted online portal is a viable alternative to that or do you think in that situation where you are talking about families perhaps dealing with a serviceman who is starting to exhibit or is exhibiting some mental health concerns, that the face-to-face contact would be the standard wish we should be aiming for?

Dr Carbone: I think, as I have tried to indicate, to some degree it is horses for courses. I think people have different levels of need. You need to try to match the solution to their particular context. Early on and in an otherwise sort of a lot of protective factors around you, familiarising yourself with the condition, learning about it and reading about it can sometimes put you in the right head space to know how to deal with it. At the more severe end of the spectrum you are going to need a team around you. You might need the GP, a social worker, a psychiatrist and also, if you have been dislocated from your family, if you are homeless, clearly you need more types of supports and services and they need to be wrapped around and coordinated.

A model has been put forward through the National Mental Health Commission called stepped care, which basically means you start at the basic level, then you build up and you build up, depending on how you are travelling. If a lot more people can be managed at the sort of lower end intensity of intervention it frees up the resources that are there for people to operate at the top of their skill-set and to deal or assist the people with the more complex needs. Now, there is an assumption built into that that you are going to be able to encourage people to start the journey of recovery at the earliest possible opportunity when they probably are most receptive and most capable of being assisted by those lower intensity or self-management interventions, but if you can you may free up capacity for people who really need that complex, coordinated multidisciplinary intervention, because those guys will not be having to treat the milder end of the spectrum. I am talking mainly about depression and some of the more common anxiety conditions like generalised anxiety, social anxiety and panic disorder.

Senator FAWCETT: We have heard a lot of evidence in this and other inquiries that the reluctance of people to self-identify or self-report even early symptoms of a mental health condition, results in them having multiple deployments whilst carrying that burden and then having severe problems later. We have also heard that early intervention is the best form of actually helping someone control that and get on top of it. I notice in your submission you say:

> Barriers associated with accessing mental health care in the ADF demonstrate the need for clear policies and procedures on how the ADF supports people experiencing mental health conditions including in what circumstances a mental health condition will affect a member's current or future deployment.

You then go on to say:

> For many individuals the mental health condition may not have an impact on their ability to do their job, nor do they require any adjustments to their workload or schedule. It should, therefore, not impact on deployability.

Can you unpack that a little bit for us because this seems to be a real hurdle for the ADF, both the members and the organisation. The organisation sees it has a duty of care that if somebody puts their hand up, that we have to care for them. We have heard from other witnesses that there is no evidence base to say that you can send someone back into a stressful situation and yet people are self-selecting to do that all the time by not reporting. Do you have any suggestions or any evidence base as to how we would shape a policy to say we can go forward to support this person dealing with early onset signs that still allow them to redeploy?

Dr Carbone: First of all, one of the caveats is the discussion earlier this morning was largely focused on PTSD, but people in Defence Force suffer more than just PTSD. The prevalent studies show that depression was probably the most common of the conditions. Anxiety disorders collectively, and not just PTSD, were also very common; perhaps compared to the general population self-reported or interview administered substance use was a bit lower. So, going to depression, it is a different kettle of fish than perhaps someone with severe PTSD. There is evidence of people being able to recover and being able to return to their level of functioning, and I guess that is what we are alluding to.

I mean return to work is a big problem. There is a stigma in self-reporting but one of the stigmas is about, once treated, people often encounter barriers to getting back to their job. They find they might not get the same job back. They might not be able to get the same hours back. In a lot of situations that is discriminatory. The person probably is able to return to that workforce and to that job, particularly with, as I said, I am making a distinction here with depression and some of the other anxiety conditions.

We are not a specialist PTSD sort of service at beyondblue and I guess we would have to defer to the experts in that particular field, but with depression, social phobia, generalised anxiety and panic disorder, if treated and under control and in remission one would expect that people could go back to a role they had. Whether that is a direct combat role, I guess as you have already indicated, some people are capable of going to that. Some people fudge their answers so that they are going to be allowed to go back to that. It is a two-way street. You have got to take a little bit of responsibility for your own mental wellbeing, but your organisation also has to look after your mental wellbeing and not expose you to hazards that could tip you over the edge.

Senator FAWCETT: You have a section in your submission where you talk about programs and services for ADF families and, as I read it, what you are saying is you have programs and services which could be accessed by ADF families.

Dr Carbone: Yes.

Senator FAWCETT: Do you have any kind of reporting or identification that indicates how many ADF families are accessing your services, or is it completely anonymous?

Dr Carbone: Yes. You are exactly right. They usually access our programs quite anonymously. We know that a lot of people come to the site, download our pamphlets, our information and resources. They phone our

telephone helpline. We know that they are making use of it, but we do not collect demographic sort of information on people to that sort of level, so we would not know.

Senator FAWCETT: Is there enough demand or evidence to say that there is a stream of resource that could be developed for ADF people and first responders like ambulance crews, firemen, policemen and so on, so that there is a resource that is available through beyondblue for a broader section of the community who work in similar kinds of high stress situations?

Dr Carbone: Absolutely. We are moving a bit more into the area of first responders' mental health, not necessarily military but first responder organisations. Mr Arvanitis can probably give you a bit more background about that, but that is an area of interest that we are developing. You can never underestimate the power and the usefulness of information resources. Demystifying conditions, laying down the facts, explaining things, what the therapists call psychoeducation, is the starting point to getting better, to understanding and being in control of the management of your health.

Senator FAWCETT: Do you have a time frame on that work?

Mr Arvanitis: We would be looking at within this financial year to have a good practice model for emergency services workers around creating a mentally healthy workplace. That will draw on some of those underlying principles that Dr Carbone was talking about that we feel are applicable to all workplaces in all industries around raising awareness, reducing stigma, providing support and prevention at the individual and organisational level.

At the same time we realise there needs to be an overlay of specificity and it actually needs to be an industry specific resource. Emergency services will not access a resource that was developed for office workers or retail staff. So, it is a combination of drawing on those underlying principles as well as recognising that emergency services are a unique profession that requires some tailored information and resources.

Dr Carbone: So, broadly across that we have different populations that we are trying to address. There is the person experiencing the problem but then there are their friends, family and loved ones around them so we have resources like having the conversation. You are worried about a friend. You are worried about a family member. How do you approach it? How do you bring it up? Those sorts of general resources could be adapted to particular population groups, but a lot of the principles would probably be similar.

Senator WHISH-WILSON: From my observations, one of the big successes of your model has been having role models, having people speaking out, especially for men, farmers and other people that are in the high-risk category. We have been given a lot of information about early prevention and stigma in the Defence Force. Would you suggest that the Defence Force adopts—and I keep doubling up on the word 'model'—your model of having role models? We see VC winners coming out and talking about Anzac and commemoration, but what do you think?

Dr Carbone: The short answer is yes. I think the research around stigma shows you basically need—and there is a term for it—the targeted continuous credible contact, so the more you are exposed to people who have been there, had that experience, are willing to recount to that, you can see that they are just regular people with a particular experience and they are willing to talk about it to you, it breaks down a lot of the myths. In targeting it, it means that it is better to have people talking about particular conditions, so 'I have experienced depression. I have experienced PTSD' rather than some nebulous, generic, 'I have had a mental health condition.' It is regular contact, seeing people as frequently as possible through media, television, movies or whatever. Credible; you need someone that you feel you can relate to, 'That is a person just like me. That person has been there and done that. I probably can do the same.' It gives people confidence to step out and say, 'Well, okay, if he or she is willing to admit it then perhaps I can', if it went okay for them.

So, I think there is a role for trying to. We have, at beyondblue, two main groups; a group called our beyondblue ambassadors who are high profile people that have been willing to come out and talk about their experiences with mental health conditions, and our beyondblue speakers bureau who are a whole host of other people who have experienced these conditions or are caring for people that are experiencing conditions. I think we have over 600 and they regularly go out. They are invited by schools, by community groups and all sorts of organisations. They give talks. They just talk about their life.

We have seen, across the Australian community, through our work but obviously the work of many, many other organisations, that awareness is going up. People are better able to identify and understand these conditions. There is an increased willingness to seek help. The stigma is gradually falling but not sharply enough. There is still either self-stigma or community stigma that inhibits but it shows that this does work. It needs to be continued. It possibly needs to be ramped up but it does have an impact and it is not necessarily expensive stuff.

Senator WHISH-WILSON: Would you suggest that in the case of serving ADF members that it would be a military or an ex-military person or people?

Dr Carbone: That would be ideal.

Senator WHISH-WILSON: That would be ideal. I know when General Cantwell wrote his book *Exit Wounds* it was quite controversial at the time that someone that senior had come out to talk about this issue, but it just seems to me that might be a useful thing to get—

Dr Carbone: If people are willing to join either our ambassadors' program or the speakers bureau or whether you are talking about having a particular program that is designed specifically—

Senator WHISH-WILSON: You guys do it well. Why not work with the Department of Defence?

Dr Carbone: Absolutely. We are trying to diversify and increase the demographics and diversity of the group that do our speakers work. We want people from any background, any walk of life and any occupation.

CHAIR: Senator Lambie, do you have any questions?

Senator LAMBIE: I do. Have you approached the vets and asked whether you could actually speak to these people on base?

Dr Carbone: No. I am not familiar with anyone having asked. If we have made any approaches to currently serving Defence personnel to be part of the speakers and ambassadors, no, I am not aware of that.

Senator LAMBIE: So, are you aware that Defence will not let those who have served, that have gone through PTSD and who are going through the issues with Veterans' Affairs, on base to warn those men and women of what they are about to come up against, either?

Dr Carbone: I am sorry, I am not quite sure that I understand the question.

Senator LAMBIE: Are you aware that Defence will not allow those who have served in the past, especially diggers, to stand up in front of people on base and explain to them what they are going to be up against when it comes to dealing with PTSD and the minefield that they are going to go through with Veterans' Affairs?

Dr Carbone: No, I am not aware of that. Obviously most of the people that work with us are in a voluntary capacity. We put out a call for people who are interested in becoming a member and becoming a part of this community. They self-select. They come forward. We support them with training and so on, but no, I am not familiar with what the rules are or what barriers might prevent certain people from certain occupations getting involved.

Senator WHISH-WILSON: Can I continue my questioning because I am not sure if you wanted clarification.

CHAIR: Yes.

Senator WHISH-WILSON: I just have a few more. Just in relation to other models that you use, you made comments about the ADF suicide prevention model and how it could be improved by adopting components of the community based suicide prevention. Could you elaborate on that?

Dr Carbone: Government is currently involved in a trial of a new approach to suicide prevention that is focused on people that have actually made a suicide attempt so we are working, at the moment, in the Northern Territory and we are soon expanding into New South Wales and potentially other jurisdictions. We know that people who have made a suicide attempt are at particularly high risk of making another attempt or eventually taking their own life, and we know that the first few months following a suicide attempt is an incredibly high-risk period. We also know that unfortunately—and this is across the board; I am not talking about any particular sector—that people often do not get good follow-up after a suicide attempt. They might find themselves in an emergency department. They might be discharged with a nominal sort of follow-up but that might be two, three or four weeks down the track. That might fall through and they are left to their own devices. Their circumstances might not have changed and they continue to be at a high risk.

We are developing a model where we have a non-clinical model so these are support workers who will make immediate contact with that person and basically just be there to try to offer support and encouragement and assistance to either relink them in with the support network in their life, to try to problem solve what the issue is that might have contributed, to link them in with GPs or specialist mental health services so they do not fall through the cracks. Now, that is just a model that we think could apply regardless of the circumstances.

Suicide prevention is a complex thing. There is no one single suicide prevention strategy that will ever work. There is some talk at the national level of trying to embed multiple strategies simultaneously in an area or a geographic region where you basically get the 10 best strategies based on research and you apply them intensively

and simultaneously because you cannot just rely on one thing to assist the problem. Our model would be one of those sorts of services.

Senator WHISH-WILSON: Are there risks within workplaces or within networks that you see suicides, if mental health issues are involved, that you tend to see other suicides within those networks and workplaces?

Dr Carbone: Yes. There is a lot of work that goes into post-intervention, so intervention after a suicide because we know there is a ripple effect and that ripple effect can sometimes create a certain level of contagion, which is one of the words used, where people who are vulnerable may start to see that and consider that as something that is an option. You have to be very careful then in the immediate sort of post-suicide situation that friends and families and others are vulnerable themselves and suicide amongst family members who have had a family member suicide is higher. So, yes, they are in that risk group.

Senator WHISH-WILSON: Earlier this year the ABC ran an extraordinary story that nine either serving members or recent veterans committed suicide off the same base at Stirling in Perth. I understand that is being investigated, but I just wondered at the time what kind of counselling and other things were in place for that workplace, whether it was something specific to that group of ADF personnel or whether it was something to do with the culture at the base or experience that might have related to PTSD or depression.

Dr Carbone: I am not sure of the circumstances of that particular situation. My colleague might know. There is documented evidence of clusters in this situation.

Senator WHISH-WILSON: Clusters, yes. That was the word that they used.

Dr Carbone: The vulnerability is there and unfortunately it can trigger. Suicide is a complex sort of phenomena. Mental health problems are a contributor but so are broader psychosocial stressors. It is a balance between what is keeping you alive and well and what is bringing you down and causing you distress. The more protection you have got it offsets the risk, so if you can intervene and offer that support and offer that protection you can decrease the risk.

Senator WHISH-WILSON: That leads me to my last question. In a military environment, whether it is training, whether it is on-base or whether it is deployment, how can you reduce some of these stressors? Is it a lot more difficult for the serving personnel, given the nature of the work they do?

Dr Carbone: There is no doubt that there are certain risks associated with the job that are pretty difficult to manage but what I found interesting, in looking at the report on the prevalence of mental health problems, was that it was not just personnel that have been deployed that are experiencing these conditions. There are clearly some other factors that are going on that are over and above or at the same time. Clearly it is like any other place in Australia or any other workplace. There is stress that is happening there that is contributing to people potentially becoming unwell with depression or whatever it is, even if they have not gone on deployment.

Deployment is a unique experience and environment and I think the measures that were being talked about earlier about the resilience training and how far you can go beyond that in terms of other measures, in terms of limiting the number of deployments, that is stuff that is beyond my area of expertise so I would not be able to comment on that. The basic philosophy of manage risk and improve protective factors is the underlying principle.

Mr Arvanitis: I can just add a point that we know from the general literature that there is a range of protective factors that can offset a lot of the stressors and those inherent risk factors that are specific to the military. Now, we know that supportive leadership and social support can offset a lot of the operational risk factors so that you might not necessarily be able to do much to reduce a specific risk factor but, if you are thinking about those protective factors in terms of social support and supportive leadership, that can reduce the risk.

CHAIR: Senator Lambie to close this session.

Senator LAMBIE: You have indicated that the transition to civilian life is a critical time, so would you be willing to support a program where veterans become entitled to trade or higher education training, as in free trade and higher education programs?

Dr Carbone: I think anything that supports anyone transitioning from one very important role and going into a new role is very important. Transition times are a time of stress for most people; so, coming from primary school to secondary school and from work to retirement are critical junctures that test us all. I think that if we are left to our own devices that most people would do okay, but if we have got some back-up, some support, some practical initiatives to smooth that transition process, I think those sort of things would make a difference. Whether that is the main or the only one that would help, I am not sure, but things like that obviously are worth considering.

Senator LAMBIE: So, have you found with those who suffer PTSD that those who are given a distraction, some hope for the future and an easy transition can actually manage that PTSD much better?

Dr Carbone: I think one of the critical things we find in mental health conditions is that there is a tendency to think that all you have to do is resolve the symptoms and everything will take care of itself, but people need the whole holistic approach. It is about your relationships. It is about your place in the world. It is about what you are doing with your time. It is about getting back to work. It is about getting back to your hobbies or whatever. Symptom reduction will assist you to participate and re-engage with things but those things are equally important and can be provided simultaneously to any therapy or medication that might be provided, and that is across the board to any person suffering from mental health conditions.

Senator LAMBIE: Are you concerned that the military does not have a maximum number of tours of duty for serving members?

Dr Carbone: That is unfortunately beyond the scope of my expertise to be able to comment on.

Senator LAMBIE: Thank you.

CHAIR: Thank you very much for your evidence here today. If you have taken any questions on notice you have a respectable amount of time to answer them. I am not sure if you did or not. It is Friday, 18 September.

BARRY, Dr Michael John, Secretary, ACT Section, Australian Psychological Society Clinical College

BRETT, Ms Maria, Chief Executive Officer, Psychotherapy and Counselling Federation of Australia

[14:17]

CHAIR: We now welcome representatives from the Australian Psychological Society Clinical College and the Psychotherapy and Counselling Federation of Australia. Would one or both of you like to make a brief opening statement before we go to questions.

Dr Barry: Good afternoon, Senators. I am a clinical psychologist. In my practice I work with Australian Defence Force personnel and veterans, amongst others. I am also a veteran myself. Prior to becoming a psychologist, I served for 28 years in the Australian Regular Army, both as a soldier and officer, deploying twice on active service during that time.

Before I go through the main tenets of our submission, we would like to acknowledge the comprehensive and substantial support which is already being provided by the Department of Defence and the Department of Veterans' Affairs to support ADF personnel, veterans and their families. What we would like to do, however, is make a number of recommendations in four key areas that seek to identify and address some of the gaps in the services being provided in order to improve mental health outcomes for ADF personnel and veterans.

The four key areas in which we make recommendations relate to education, research and mental health literacy and, in particular, two issues: barriers to treatment seeking amongst both ADF members and amongst veterans and provision of training to assessing specialists into the unique needs of veterans. The second key point relates to transition and continuity of care, in particular between Defence and civilian primary health providers and between Defence and DVA with respect to members not seeking a pension or compensation. Thirdly, we would like to make recommendations regarding quality mental health care and services: in particular, training for the treatment providers about the needs of veterans; meeting the needs of regional, rural and remote, homeless and disabled veterans; providing support for family members to access public and private health services in the areas of marital, partner and family psychological treatment; providing funding for travel and local accommodation for families while veterans are in acute inpatient treatment; and, seeking greater acknowledgement and funding for sub-clinical conditions such as anger, sleep disturbance, memory and cognitive function. Finally, the fourth area is around strengthening workforce and partnerships; in particular, between police, ambulance and public mental health services around the needs of veterans and seeking better integration between private, public and publicly funded services and service providers. Thank you. I would like to invite any questions.

Ms Brett: Perhaps I will speak first. The Psychotherapy and Counselling Federation is the leading peak body for the counselling and psychotherapy profession. Psychotherapy and counselling focus on the prevention of mental illness and the provision of psychotherapeutic interventions for psychological difficulties, while actively promoting mental health and wellbeing. Counsellors and psychotherapists use the therapeutic relationship to enable people to develop greater understanding of themselves and make positive changes in their lives.

I just wanted to focus on a couple of issues in the submissions that were made. Firstly, I want to really highlight the importance of early intervention counselling services. A key barrier to the delivery of effective counselling for ADF personnel and their families is the fact that some people do not choose to take up or delay taking up the services available and research is very clear that early intervention improves treatment outcomes, so improving uptake of counselling is clearly a high priority. I want to highlight the importance of early treatment of alcohol abuse, in particular, because it is likely to be one of the first psychological signs that may present, so early treatment of substance misuse issues can really help to reduce the risk of deterioration in the mental health of that person.

Now, while the medical model which involves the diagnosis of mental disorders may be necessary, it seems to entrench stigma with some people. It is not surprising that for some ADF personnel this medical approach discourages them from accessing services, and with so much stigma still attached to seeking help for mental illness I think there is a need to normalise counselling with the ADF. So, this is while people are still serving but also after transitioning back to civilian life. I think we need to get a place where counselling is just seen as what you do to get support with any difficulties that you might be having or with your transition.

I think it is important to have the client firmly at the centre of any treatment or support that is provided. That is very much the way that counsellors and psychotherapists train and how we work, and this relational approach to counselling is really important because if a client has a bad experience, say in the very first session, of not feeling rapport with the therapist, they can actually terminate immediately after the first session. So that therapeutic relationship is really core.

Now, just to highlight a couple of really important things from the research evidence, there is strong evidence that providing services according to client preferences also improves therapy outcomes. So the client preference might be the preference they have to see a particular type of therapist and actually some clients might prefer to see a counsellor rather than a psychologist, but also clients might have preferences around interventions. Now, of course, interventions should be evidence based but we know from the research that cognitive behavioural therapy does not work for everyone. There are other specialist interventions that we have highlighted in our submission including art therapy provided by a qualified psychotherapist trained in art therapy and body focused interventions. Body focused therapy also offers a very promising alternative tool where traditional talking therapists might fail, so the focus is much more on the bodily experience, and that is certainly more effective for certain people.

Also in treating PTSD, talking therapies can have a risk of re-traumatisation. This is where both art therapy and body focus psychotherapy can be very beneficial because they are a much more gentle, supportive approach rather than directly talking about something that was very traumatic. That is probably all I have got time to talk about, except perhaps just to mention one more thing and that is relationship counselling. This is another specialist area that counsellors and psychotherapists are very often trained in and I noticed that the VVCS does offer some relationship counselling but it appears to be quite limited. Couples counselling and family therapy can actually be, for some people, the most effective form of treatment for substance misuse. It can help to reduce family violence and improve relationships.

So, I think all of these specialist interventions are very important. Perhaps it is a way to start picking up the third of people for whom treatment, as we heard earlier, is not actually effective. Sadly, counsellors and psychotherapists are not currently part of the DVA workforce. Senator Fawcett picked up this point earlier that it is perhaps about mental health competencies and training in these specialist fields which is more important than the actual profession that you might come from. So, that is perhaps all I will say for now.

CHAIR: Thank you very much for those opening submissions. A question to you, Ms Brett. If you are absent from the DVA menu of solutions, where are you active? Where are your success stories?

Ms Brett: Well, counsellors and psychotherapists often work in agencies, so we might be working in the non-profit sector, working in family relationship counselling and drug and alcohol counselling, so a lot of those kinds of areas we are active in but also in private practice.

In 2010 DVA moved towards the statutory regulation of the practitioners that they use and what they did at that time is they stopped running their own list. This was in 2010. They stopped running their own list of practitioners—and counsellors and psychotherapists used to be on that list—and they adopted instead the Medicare list, so we were excluded at that point. Now, no doubt there was some rationale for that change. Perhaps it was more efficient for them to adopt the Medicare list, but at that point we were excluded not only from other mainstream mental health programs such as the Better Access initiative because we do not have Medicare numbers. So, we have actually been in discussions with the health minister, which we are very encouraged about, about the possibility of Medicare numbers for counsellors and psychotherapists. If that were to be approved then basically the DVA would be able to add counsellors and psychotherapists to the list of providers that they currently use with Medicare numbers.

Senator WHISH-WILSON: Can I ask you both whether you think the kinds of services that you are advocating for should be in-house for Defence and for DVA? We have heard different evidence. You are saying, Ms Brett, about the outsourcing and the privatisation of services to vets in general has created a loss of not just brain power but knowledge, intellectual property and the atmosphere that used to treat vets like in special veterinary hospitals and those kinds of things that has led to this disassociation. Do you see any truth in that?

Dr Barry: When you are talking about in-house do you mean in terms of within the Defence Force or within DVA as well?

Senator WHISH-WILSON: Within both.

Dr Barry: One issue there is firstly access to services. You have heard a lot of submissions today regarding stigma and the difficulties of seeking treatment in-house and the impact on careers. That being said, one of the major tenets of treatment is that if you can treat as close to, in a sense, the front as possible then there are better outcomes, so treating a person while they are still within the organisation in which they feel that they belong means that they are working within the culture in which they are familiar. Treating a person within an environment where they are amongst other, in this case, veterans, once again provides a supportive environment where they feel that there are people that understand what is happening.

One of the concerns with outsourced treatment—and I am a private provider myself—is expertise in the unique needs of veterans. That is where we, in the APS, believe that there is a need for more training of all service providers, regardless of their specialisation, into the needs of veterans and also into the needs of assessing officers who are assessing people for compensation claims.

If I can just very briefly give an anecdote, there is a lot of anecdotal evidence about difficulties with the assessment process, which is rather arduous. A veteran client of mine described a 20-minute interview with a psychiatrist for an assessment for quite significant PTSD and depression symptoms. He said that at the start of another assessment he was told by a specialist that he 'should not have deployed to the Middle East because it was an immoral war'. Needless to say, that assessment did not go well from there and I believe he has put in a complaint to DVA about both of those officers, but it really just highlights the need for education into the needs of veterans and the unique nature of military service. We are not just investigating someone's claim for a workplace injury.

CHAIR: But illness is illness. I mean if I was ill I would just want the best treatment possible.

Dr Barry: That is correct.

CHAIR: I do not particularly want an ex-truck driver to treat me because I come from the transport industry. Really, illness is illness. I know there can be exceptions and stories, as you have said, that are quite inappropriate but if someone presents with a depression or an illness, why does it have to be someone who understands the Army to treat them?

Dr Barry: I am not necessarily saying someone who is ex-Army. I am saying someone who understands a little bit about the culture in which the person operates. The organisational culture, even in the transport industry, has its own very unique culture. As the previous presenter discussed, the needs of a veteran, the needs of a police officer or a fire officer, are very different to the needs of a retail worker or an office worker. Understanding the culture in which a person operates is a very important point in establishing the rapport that is essential for creating effective treatment.

Senator WHISH-WILSON: We heard that from a person yesterday as well who said a very similar thing. They said they did not have a problem with the quantity of services available but it was more about the empathy that they got when they met with their counsellors. You also mentioned that you want more importance put on identifying veterans at first contact and to facilitate a no-wrong-door approach.

Dr Barry: Yes.

Senator WHISH-WILSON: At the moment, if I am a Vietnam veteran or a contemporary veteran—if the two are not the same thing—and I go in to see the doctor about getting some antibiotics for a throat infection, is there any way of identifying that I am a veteran? I know some doctors do ask whether you have DVA entitlements, that kind of thing, in the forms you fill in, but what do you mean by identification in that sense?

Dr Barry: If all ex-serving-members were connected with DVA when they left the service, then first, DVA would be able to maintain a record of everybody's health, including those who were not seeking support and seeking pensions, or seeking treatment. In addition, they would then be able to provide education and advice around education and resources for those who subsequently further down the track decide that they need to access that support. As many veterans will testify—and I am sure that they have in this hearing—the process of applying for support is lengthy and arduous and is a significant barrier to seeking treatment and to seeking support.

Ms Brett: Could I come back and add something in response to an earlier question about in-house services? I can think of two other issues; and I support what Dr Barry said. One issue is whether the veteran has confidence in those in-house systems. When I have spoken to veterans, they do not always have confidence. Actually, they do not necessarily want to stay in-house. The other issue particularly relates to rural and regional areas, because we know there are workforce shortages. If you are trying to access one of the outreach counsellors from VVCS and you live in a place where someone is not available, you will actually be waiting, and that sometimes can be for quite a significant amount of time to get a service. This is why, in our discussions with the health minister we are very interested in potentially using counsellors to participate in a rural and regional trial, and that could be something potentially that DVA—

Senator WHISH-WILSON: For veterans or just generally?

Ms Brett: Well, DVA could participate in a trial. We are talking to the health minister about a trial in general to try to find a solution to this workforce shortage in those areas, but it would be really good to see DVA participate in that kind of trial so we could specifically look at using counsellors to fill some of those workplace shortages for the veterans needing a service.

Senator WHISH-WILSON: What about the bigger picture in terms of disaggregating services and outsourcing? Do you risk losing that body of knowledge? We have heard from some submitters today that coordinating all of these different groups is quite chaotic, and you have given an example of where you were cut out of something that you were doing perfectly well because of a Medicare number. How do you coordinate these things better to get more research done to respond to these situations? Is there a culture that everyone is working together on this issue?

Dr Barry: I think at the moment that is an idealised situation that people would like to see, but most people are so busy keeping up with their current workload, trying to work with people outside of their organisation; for example, Defence Mental Health connecting in with DVA, connecting in with private providers, connecting in with non-government organisations. There are a lot of difficulties in doing that, because people are just busy keeping up with what they are trying to do at the moment. The other issue with in-house services—just picking up on what Ms Brett said—there is a major concern for serving members about the confidentiality of the information that they provide. One of the benefits of an outsourced service is that there is more confidence that the information they provide is maintained confidential.

Senator WHISH-WILSON: That is a question I actually wanted to ask you. It has been suggested that there is a lack of emphasis on prevention and strengthening mental resilience. As to the sharing of information, when you are serving in the Defence Force—and Dr Barry, you have been in there yourself—do you buy into the idea that, for example, commanders should have more information about the mental health of their troops?

Dr Barry: That is a vexed issue. Am I here as a former serving member? Am I here on behalf of the—

Senator WHISH-WILSON: I understand that, but you have that perspective.

Dr Barry: As a former commanding officer, I felt that I needed to know about the health of the people under my command. As a health professional now, I respect the needs of confidentiality and privacy of the people I am treating. This will always be a vexed issue. What is needed is for people to be able to have faith in the chain of command that their commanders are not going to make decisions based on short-term results, short-term responses, rather than looking at the longer term outcome of treatment, and providing time for treatment to take effect.

Senator WHISH-WILSON: We even had one submitter who said that, for example, I use the word 'commander' loosely, but commanders should actually sit in on assessments of their soldiers.

Ms Brett: I would not agree with that. I am a counsellor myself, and confidentiality is actually not a black and white thing. When I discuss confidentiality with a client, I talk about certain situations where it may be necessary to disclose certain information. If that information is delivered in the context of good therapeutic rapport, that does not necessarily put clients off. If they trust you as their counsellor, they will understand that there might be certain situations where you need to report. Where someone is at risk, either your client or a third party being at risk, I think clients understand that. If they are at risk of serious PTSD by not disclosing their mental disorder and going on another deployment, then that may be, in that context, one of the exceptions to the confidentiality rule.

Dr Barry: If I could pick up on the other points of your question where you talk about resilience, and just building on the beyondblue submission, we use the term 'psychological education', and it is very common within the counselling and psychology community, which is the provision of information and education around mental health issues, around treatment, and that is a vital step in the treatment process. Once people understand what is happening and why it is happening, that is a big step in moving towards recovery. It leads very nicely into: this is how we now go about treating this. That provides that sense of hope, picking up on your question to the beyondblue presenter, about instilling hope in the veteran or in the soldier about the treatment process and about recovery.

Senator WHISH-WILSON: Could you actually clarify whether what Senator Lambie asked was correct? Is it true that someone experienced in this area is not able to stand up in front of Defence personnel and talk about your experiences and issues surrounding mental health and destigmatising it? Are you aware if that is true or not?

Dr Barry: That would be a question for the Department of Defence. I could not comment on that.

CHAIR: Perhaps you might take up your line of questioning.

Senator FAWCETT: Thank you. You say on page 3 of your submission, talking about DVA, that the problem is that, while a whole-of-person approach to treatment that endorses the role of such networks being carers, children and family is recognised by DVA as instrumental to recovery, only a highly restricted range of services is available to families. Given that this inquiry is about the mental health of serving personnel, would you say the same thing about Defence? Do they recognise it, and are the services similarly restricted?

Dr Barry: Defence provides some support to families through the Defence Community Organisation, there is certainly recognition of the need to support families of members who are deployed, and members who are returning from deployment. I am not up to date with current Defence policies around educating families, but I do know that in the US they have as part of their resilience their BattleSMART program, not just training for deploying members prior to deployment and for reintegration after deployment, but also they provide education to families around supporting their loved one who has returned from deployment and in coping with the deployment themselves. I am not familiar with current policies in the ADF on that.

Senator FAWCETT: So you have had no exposure with the Reserve Assistance Program, for example, that provides support for reservists and their families?

Dr Barry: I left the regular Army at the end of 2006, and then I finished working part time with the reserve in about 2011 due to other work commitments, so I am not familiar with, over the last four or five years, what sorts of programs have been put into place.

Senator FAWCETT: One of your recommendations regarding education research and mental health literacy was to address the stigma and break down the barriers that prevent individuals from seeking care. I think you have probably heard my questioning along this line to other witnesses. One of the significant barriers that we continually hear is that people are afraid that, once they self-identify, their promotions, their career, their potential to redeploy will be stymied. Given that currently we have a sizeable number—I do not think anyone can measure it—who self-select to not report and deploy again, and sometimes two or three times, from the APA's perspective is there a framework that Defence could put in place and say, 'We are better off to have these people identify, get some help, and if they choose that they want to redeploy, with appropriate duty of care, we can work with them and help them do that', or from APA's perspective do you think once someone has identified that they have an issue then Defence does not have a basis to actually redeploy them? Is there a way forward to remove that significant barrier that people have?

Dr Barry: There is a lot of evidence to suggest that, certainly at the lower level, people with lower level mental illness can deploy and can carry out their function. Recognising that, where we draw the line is, of course, a very difficult issue. Education is a really big part of the answer to that. Also, taking up that question around access to bases and having people with mental health conditions or who have been successfully treated, coming back and talking to serving members from a personal perspective I think is a very good idea. I cannot comment on Defence policy, but I think the APS would certainly support that as well. In the ACT, we have an organisation called Mental Illness Education ACT, and they provide speakers who have experienced mental illness themselves, and they go out to schools, organisations, community groups, and we get them in at the university where I teach as well, talking to the students around their experience of mental illness. That goes a long way to breaking down the stigma and to saying that somebody can have a severe mental illness yet still live a functional life.

Senator FAWCETT: Anything further to add?

Ms Brett: No, I think that is all.

Senator FAWCETT: Another recommendation you had was around purchasing services that best meet the clients' needs and are evidence based. We have had evidence from previous submitters that some purchased services see quite a high turnover of providers, so somebody has to re-tell their story countless times. This kind of builds on your comments before about understanding the context of the service. How important is the continuity of relationship between somebody who is seeking support and the professional provider who is providing it? Even if we still purchase services, should a condition of that purchase be a guaranteed continuity of the client-provider contract for a period of time, or should we be going back to in-house in order to provide that continuity?

Dr Barry: I do not think the problem would go away if it was in-house, because people get posted, people go away on courses and other forms of training, so continuity of care would be just as big a problem in-house as it would be if it was outsourced. Continuity of care is a major issue, and I think as we have both said, the rapport that is built between the client and the therapist is a major part of the success of a treatment program. One of the difficulties that a lot of clients face is not just continuity of care with the treating provider but also the case worker, the case manager, either DVA or in the case of insurance companies rehabilitation companies and providers, that continuity of support. So once again, they are continually re-telling their story and trying to explain to someone else what is happening. The more that we can encourage stability of provision of care, that has a major impact on successful treatment.

Ms Brett: I would add something to that. I think it is really problematic to try to enforce continuity of care, because actually if the therapeutic relationship is not working for a particular client, of course they should move on to a different therapist. I think the question I would be asking is: why is that initial therapeutic relationship

failing so often? The biggest factor, really, in the success of therapy is that therapeutic relationship. Is it that those therapists do not have the relational skills to build rapport? Is it that the initial assessment session does not have a range of different therapists to actually allocate to that client? It may be that particular clients, once you assess them, you might be able to identify which type of therapist might work best for them. I think there are lots of ways that you can start to perhaps ensure that people are not jumping from one therapist to another. I do not know what outcome measures are currently collected, but to try to get client feedback about what it is they like about therapists and the treatment and what is not working for them, I think that would be really useful data to have.

Dr Barry: The public mental health provide some very effective and very good services, but I have seen a lot of anecdotal evidence about people who have gone along and in five sessions seen five different therapists, simply because the therapist is not available. So you have the problem with the therapist being available, but also building that rapport and that relationship in the first place.

Senator WHISH-WILSON: Ms Brett, you said that would be useful evidence to have, and we have heard this from similar witnesses today. Who will collate that kind of evidence? How do we get a coordinated approach? Is it more money for research?

Ms Brett: I cannot comment on what data collection DVA does at the moment, because we are not involved in those services. But there are lots of really simple ways that you can measure client satisfaction or client preferences, which I mentioned earlier. It does not have to be onerous for either the therapist or the client. It might be five or six simple questions at session one, session six and six months later or something like that. So it does not have to be a difficult process to collect that data. I do not know; do you know if DVA collects that kind of information?

Dr Barry: Not as far as I am aware. In addition to my private practice, I also teach in the clinical program at the ANU. So I am teaching students who are doing their graduate clinical training, seeing their very first clients in their first placement. As part of their training process they provide the clients with evaluation forms at the end of a session, and the client rates the outcome and their progress during the week, but also their satisfaction with that session. As Ms Brett said, they can fill out very simple five question questionnaires that provide us with feedback about how they are connecting with the therapist.

Senator WHISH-WILSON: Can I read you a statement that Phoenix Australia, an earlier submitter, said? This is directly in relation to this. Their submission recommends that DVA continue to work on delinking treatment entitlements and eligibility for compensation, noting that there is a lingering perception amongst veterans that they must remain sick if they are to optimise their compensation entitlements. Do you agree with that, or do you see an issue with that in relation to what we are discussing here?

Dr Barry: If we are connecting treatment and compensation, then they are muddying the waters. Somebody may want treatment, but they are not necessarily seeking compensation. Where there is a perception that a person is seeking compensation, then the person doing the assessment, the person doing the evaluation, the case manager, will always be looking for signs of malingering, signs of secondary gain. Where the focus is on treatment, then that secondary gain disappears.

Senator LAMBIE: I will ask you a few questions on medico-legals. There seems to be a problem out there with the Department of Veterans' Affairs that has its own psychiatrists that it uses. I think we are all very well aware of that. Most of those psychiatrists will give you 10 per cent or less for your overall determination, yet your psychologist or your psychiatrist will come up around the 34 per cent. That is your own psychologist, your own psychiatrist that you have been seeing for a number of years, and your GP, and they will all come together, yet a medico-legal can come in and in a 15- to 30-minute session and say, no, you are 10 per cent, and no, you do not have these issues, and the medico-legal wins out. Yet you have all this evidence based stuff over here from your GP, your psychologist and your psychiatrist. Are you coming across that, Dr Barry?

Dr Barry: Yes.

Senator LAMBIE: Right. So we have a problem. This is one of the biggest issues I have, and I do not think it just has to do with mental issues; there is also the physical side of effect. They are not listening to the GPs and they are not listening to the specialists that the veteran or the serving member or ex-serving member has been seeing for years and years; they take in a document from a medico-legal that has seen you for all of 15 minutes or 30 minutes, and saying that is what they are taking. This is causing absolute detriment to their health because they then have to fight this system through the court.

Dr Barry: And that is when we say that the assessment process is arduous. But also there is a need for better education of the assessment officer that is appointed by DVA, be it a medico-legal expert or be it the treating psychologist or psychiatrist. They need education into the population that they are assessing.

Senator LAMBIE: At the top of DVA, we have a board of doctors, a board of GPs; is that correct?

Dr Barry: Yes.

Senator LAMBIE: Do you know much about that board, the so-called medical experts that sit at the top? There are half of dozen of them, I believe. I cannot really quite get the answers that I am looking for on what they are supposed to do, but they are actually supposed to look at this and guide this through. Is there anything that you can add to that about that group of doctors sitting at the top of DVA who are supposed to be guiding all of this?

Dr Barry: I could not comment on their role or what they do, but what I do know is that once a person is accepted by DVA, quite often the treatment or the support provided is substantial, in terms of logistic support, travel and medication, et cetera, plus in terms of listening to and responding to the treating practitioners. Getting a claim accepted seems to be where the stumbling block is.

Senator LAMBIE: Is that because of the statement of principles?

Dr Barry: That would be a question for DVA.

Senator LAMBIE: Obviously, you have served, you have done your time, you have been a commander, and you are a psychologist; does DVA bring you in or listen to a great deal of your input? I am quite sure that your input into helping these men and women who have served, and veterans, would give them a great deal of knowledge on how to fix some of these issues. Do they use you in that capacity at all?

Dr Barry: I have had no difficulty talking to DVA when I have contacted them about a client or seeking support. If they contact me for a review or an update, then they seem quite open to listening to my advice and what I have to say.

Senator LAMBIE: Is that advice accepted and taken on board and actually put into practice?

Dr Barry: That would rely on the individual case managers. Individual case managers will take a very different approach, because they are very different people. As with any organisation, there are some case managers whom my clients will say they put a lot of faith in, and whom they trust, and other case managers whom they do not.

Senator LAMBIE: Yes, it is a bit of hit and miss. Have you had many sexual abuse victims, military wives, come through your practice?

Dr Barry: One person who was not in the nature of sexual abuse within the military, so a person who was abused on deployment, but not by military personnel.

Senator LAMBIE: What are your thoughts in reference to whistleblowers and victims of sexual and other abuse in the military who trust the current system run by the military to protect them and deliver justice? Do you actually believe that sexual abuse victims can go back to leaving that in the hands of the military to be able to fix those situations?

Dr Barry: I honestly could not comment on what it is currently like for whistleblowers in the military, except to say that, within any large organisation, any whistleblower, whether it be about a policy issue, a personal health issue or personal treatment issue, or in this case a sexual abuse issue, is likely to face barriers to being supported. That is an organisational human nature issue rather than specific to the military.

Senator LAMBIE: So it probably should be left with independent rather than putting it back into the hands of the military; that is what I am asking you. That is a problem we are having with sexual abuse at the moment. The other question relates to offsetting. Some of your clients coming through are being offset, so they have two or three mental illnesses and they are being offset from one to the next, so they are not getting any more of a payout. If they have PTSD and alcohol abuse, and they have already been given 20 per cent payout for their PTSD, and then they are given another 10 per cent for alcohol abuse, that is not then added on, and they are saying you already have 20 per cent so we are not paying you any extra compensation. Are you getting any of that coming through your practice?

Dr Barry: I am not aware that that is happening, so I am afraid I would not be able to answer that question.

Senator WHISH-WILSON: Mr Brett, you have already commented on some alternative therapies in your opening statement, which I was interested in. It has been suggested that pharmaceuticals and electro-convulsive therapy are over-valued and over-used by psychiatrists in the treatment of PTSD. Would you like to comment on that?

Ms Brett: I am not a doctor or a psychiatrist, so I cannot specifically talk about those treatments. My understanding is that, in certain more severe cases, it may be appropriate to have those treatments. I guess from my point of view as a counsellor, I would be interested to find out how far we can get with a talking therapy,

actually. That is not to say that the psychiatrists do not have a place in recommending those other treatments, but that should not be at the expense of evidence based talking therapies that we know are effective, and also see those talking therapies in a wider context. We heard earlier from beyondblue about the family relationships, the work opportunities and social opportunities; you cannot treat someone's brain and expect that to fix a problem 100 per cent if work employment, social life and meaningful activities are absent. I think the psycho-social context is very important. I think that is where counselling can actually help to support someone to have all of those needs met.

Senator WHISH-WILSON: They are probably really used, though, in the original confronting of, I suppose, memories, and then the other types of treatments are used separately. Would that be a simplistic way of looking at it?

Dr Barry: We do not just use treatments that confront the memory. That is one form of trauma-focused treatment. There are other forms of treatment—EMDR, eye movement, desensitisation and reprocessing—and that is very effective in treating PTSD. For more complex trauma we tend to use deeper level therapies such as schema therapy that looks at the underlying beliefs, attitudes, values that are created through repeated traumatic exposure, where there is not just one or two specific events that we can target.

Senator WHISH-WILSON: We did hear from an earlier witness today that nearly two-thirds of the serious cases that have ongoing treatment are not fully recovering and that therefore there is a need for looking at new types of ways of treating these issues. Do you agree with that?

Dr Barry: It depends. What type of issue are you talking about?

Senator WHISH-WILSON: I will have to get you the exact detail. They are talking about PTSD.

Dr Barry: PTSD is a very broad term. It covers both a single event trauma, single event very individual trauma—for example, a vehicle accident is very different to being raped—then to multiple trauma, so if it is a matter that occurred in combat, or a matter that occurred through a history of childhood sexual abuse. To label the whole area of PTSD and say that one form of treatment is appropriate or not does not quite capture the complexity of it.

CHAIR: All right, thank you very much for your evidence respectively. If you have taken any questions on notice, they will be required back by 18 September.

Proceedings suspended from 15:00 to 15:11

FRAME, Professor Thomas Robert, Private capacity

CHAIR: I welcome Professor Tom Frame. Would you like to make a brief opening statement before we go to questions?

Prof. Frame: I would, thank you. I am grateful for the invitation to attend this hearing and to say something very general about the moral injury project being conducted at the Australian Centre for the Study of Armed Conflict in Society at UNSW, Canberra, and the way in which this would bear upon the wellbeing of service personnel. This project has been underway since July 2014, and the first public output as a collection of essays to be published by UNSW Press on Remembrance Day 2015 under the title *Moral Injury, Unseen Wounds in an Age of Barbarism*. By way of personal introduction, I served for 15 years in the permanent naval forces before becoming an Anglican priest and made an Anglican bishop to the Defence Force. I have authored several works dealing with the moral dimensions of uniformed service, including a book on the 1964 HMAS *Voyager* disaster and the ethics of armed intervention in the post-Cold War period.

I will make a few contextual remarks before defining moral injury, and then touch on the terms of reference of this committee. There is nothing new in the notion that individuals are morally affected by their involvement in armed conflict. Historically, both the individual and the society on whose behalf they would have fought recognise that participating in the taking of life and the destruction of property had a bearing on moral wellbeing and, although there may have been political or religious sanction to do so, war disrupts personal value systems and sometimes reorientates a person's moral compass. For some uniformed men and women, it does not matter that they acted within the law when their actions involve a departure from the moral norms and ethical principles that have previously given direction in their life and which reflect the civilised standards of the community to which they belong. A part of them has been injured.

In the past 40 years there has been a distinct shift in the language used to describe the unseen wounds that some deploying personnel incur. The inclusion of PTSD in DSM3 published in 1980 had, I would contend, the unintended but profound effect of capturing all unseen wounds within an ever expanding definition that, to some degree, has turned moral dilemmas into psychological conditions. This was not intended, and many psychologists lament the assumption gaining currency in the press and in the public mind that every non-physical wound is PTSD, and that familiar expressions of the moral self, such as regret and remorse, shame and guilt, or even bitterness and resentment, are symptoms of moral distress when they are an integral part of a moral life. It was 50 years ago that Michel Foucault drew attention to the medicalising of social problems.

In looking at the deployed experience of uniformed men and women, I think we need to avoid psychologising what may be moral problems and best dealt with in that realm. I am not a psychologist, but I am concerned by the emerging assumption that psychology is the starting point for every question about the inner wellbeing of uniformed men and women. My concern is shared by researchers in a range of disciplines, a range of disciplines, who have started exploring the notion of moral injury as a better description of the unseen wounds that affect predominately young men and women who are given the task of implementing Australia's security, defence and foreign policy.

Now to my brief definition of moral injury. There is a consensus emerging that moral injury is associated with the disturbance, disruption or diminishment of a uniformed person's moral outlook and the depletion, degradation or disorientation of their inner moral compass as a consequence of operational service, be it warlike or non-warlike. It is plainly not synonymous with PTSD.

The incidence of moral injury is not predicated on a traumatic experience. A traumatic event may cause moral injury, but a person can be morally injured, an injury perhaps manifest in personal guilt and shame, whether justified or not, or indifference, perhaps, to human pain and suffering without the causal event itself being traumatic. Moral injury does not flow from external stress but from internal reflection. It has to do with what a person themselves makes of what they see, hear, smell, touch and taste while on deployment. So, two people can experience the same thing; one will be unaffected while the other will be injured. The difference is how they interpreted their experience in terms of the value structures ordering and regulating their inner being.

While operational service might impose an inordinate number of physical and mental demands and be the cause of intense stress, moral injury arises from existential dissonance associated with comparing idealised conceptions to concrete realities. In other words, there is a sharp disagreement about how things should be and how they actually are. So, in reflecting upon a morally challenging experience, a morally injured person realises they were not the individual they had previously believed themselves to be or hoped they were. This realisation, 'I am not the person I thought I was', causes discomfort and even despair. I would suggest it is part of living life and maturing to realise who you are and who you are not.

The morally injured person can be debilitated by their injuries in a number of ways. He or she could abandon notions of right and wrong, good and bad, as they inhabit a world in which only legality defines morality. So a morally injured person could become completely hostile to all forms of authority and suspicious of every institution exercising any kind of power. The morally injured could be paralysed by unremitting guilt and unrelieved shame with no creative or constructive forms of confession and absolution, forgiveness and reconciliation.

Another outcome of moral injury is perhaps ambivalence towards wrongdoing and corruption, and a casual attitude to injustice and oppression. Manifest in someone saying, 'Thus is the world, thus it always has been, thus it always will be, and I can't change it.'

There are a number of responses to moral injury. I think each begins with meaning-making. The greatest challenge is incorporating moral confusion and existential chaos into a coherent personal story. For instance, a combatant who has inadvertently killed an innocent civilian could be so affected by remorse and guilt that their self-image is marked by loathing and disgust, and they could have good reasons for feeling those things. But they may not have seen the body of the person they killed for them to sustain a moral injury. It was their own reflection on what they did, or what they thought they did, or what they thought they should or should not have done that is the cause of the inner turmoil. It is a moral assessment of their actions that dominates their inner being and perhaps makes them captive to guilt and liable to condemnation. But I do not think those things necessarily are signs of mental ill health; they could actually be forms of moral maturity.

The overall aim of our project is integrating the morally injurious experience into a revised or renewed self sense of one's self. To some degree, this has been happening in literature since the Boer War, where Australians have had to come to terms with campaigns they have not liked, either the doing or the fact. Plainly their moral injury is not a peculiar form of PTSD, but it touches directly on personal wellbeing. For me in my 15 years in the Navy, I look back and upon it in a certain moral kind of complexion. That will be true for people who have seen operational service, which I readily confess I have not. But the confusion and conflation of moral injury and its cognates with PTSD I think is a consequence of early writers starting with definitions of PTSD, which to my view remain highly fluid, and attempting to locate moral injury within its conceptual categories, and perhaps to some degree it ought not to be there. It is for this reason that thinking about the personal wellbeing of uniformed people needs to start, I think, to be broadened well beyond the limitations imposed by the rather narrow constraints of mental health to include the kind of work being undertaken by my centre at UNSW Canberra and elsewhere. I appreciate the chance to speak about that work, and I welcome now your questions.

CHAIR: Thank you very much, Professor Frame. We also welcome Senator Xenophon; are you there?

Senator XENOPHON: I am here, Chair.

CHAIR: Okay, we will not forget you. We will come back to you for questions.

Senator XENOPHON: Thank you, Chair.

CHAIR: We will start off with Senator Fawcett.

Senator FAWCETT: I am just interested to understand to what extent this is an isolated research project, and to what extent are you working with Defence and DVA, and I guess to extrapolate that, I know the US Marine Corps, for example, their head psychiatrist is doing some work in this field, but to what extent are allied nations exploring this concept and making it part of their holistic approach to working with people who have deployed?

Prof. Frame: I will take the first part. At the moment we have a proposal in with the Office of the Vice Chief of Defence Force to have some support to be able to have access to serving personnel and to some funding to help us get a sense of the extent to which moral injury perhaps may, might, might not be affecting people who have deployed and who are now continuing to serve. I know that you have heard anecdotal evidence today, but we have heard that kind of thing as well, where people have said when I have spoken about this, 'That actually better describes my situation than what is generally understood to be associated with PTSD; can I hear more about that?' Certainly at a conference that we had with Army in June looking at challenges and lessons since 1999, I was quite overwhelmed by the number of people who said, 'I didn't consider myself to be kind of mentally unwell by virtue of my deployment, but I am kind of morally wracked by the things that did and did not happen during that period that I was away.' So this, in one sense, has allowed me permission to think that others are so reflecting and therefore this is naturally, if you like, a corollary of service of this kind.

In terms of the other nations, I think probably the Canadians are the ones who are doing work that is probably the most advanced and of a similar kind to Australia. If it is the case that, when we send people overseas and there is a clash of cultures, they come from a culture to a culture, and I suspect that, in terms of our operating partners, the Canadians are quite similar to our own. Therefore, if we want to do comparing and contrasting between our

experience and that of one of our partners, I think the Canadians are best, and we are contacting them, if nothing else at this early stage, to find out the kind of language that they are using to describe the experience of those people while overseas. I think for a number of nations the four of which I am most familiar, in addition to ourselves, are the Canadians, the British and the United States. We are looking at this from the point of view of saying: are we talking about something similar and, if we are, do we then have to refract it through the cultures that people imbibe when they deploy and to which they then return, and even look at things like commemoration to see what kind of story we do in commemoration and how that fits in with what someone may then have experienced. So it is kind of early days, but it seems to me that your interest in hearing about this is good, and it opens up another possibility in looking at the overall wellbeing of uniformed men and women.

Senator FAWCETT: We have heard for people who are 'classified' as having PTSD or somewhere on the range of mental health injuries, about 30 per cent do not respond to normal, accepted treatment. Do you have any indications from your project or other work that potentially some of those 30 per cent could fall into a category where it is more along this line? Secondly, what is the answer to support people if they fall into this category? How do you work with them to help them move through that?

Prof. Frame: Let me take the first bit if I can. I would imagine that there are all sorts of issues that people have who are in that non-responsive category, and there are all sorts of conversations that go on in their head. It may be that they cannot get a memory out of their mind, but it also may be something that they did, the service to which they belong did, or the state of which they were, if you like, an instrument at one point did. I would not mind betting that, for almost all of those people, there will be at some point a moral dimension to what they are feeling. They are unhappy with themselves; they are discontent with the service, and they have a gripe against the society that sent them. All of those things sometimes do not have a kind of focus in a narrative, a narrative which says something about themselves and who they are, the service that they belong to and what they thought it was like, and the state that sent them and the things it allegedly publicly holds dear. So there is part of a bigger conversation that that person can have—if you like, more grainy, more variegated—in which, for instance, they are encouraged to think, ideas, to look at themes, and even to kind of reflect upon what they did in a broader context.

I know certainly that some people, when they deploy, think only about what they did, but it is part of something much bigger, and maybe it is that connection that is lost. The people that I have dealt with closely when I have talked about this and said, can I talk more, what they found kind of helpful in many ways is that one particular exercise that we undertook with some people was to say: what would you wish to say on Anzac Day about what you have done and what you would want perhaps others to hear in that commemorative context? It perhaps has not been what people have expected.

In other words, they hear certain narratives on Anzac Day but that was not my war, that was not my operation, that was not my experience, and that is not how I found I was reacting to what was put in front of me. Again, it would be misleading, I think, to suggest we have gone further on how we deal with it, other than to say that, for many people, do not think this is a matter of mental ill health, think this is about a moral challenge that you have faced, and perhaps you will have to deal with it for the rest of your life. I know in my own naval service there was an occasion when we fished body parts out of waters in South-East Asia, and it was not that we fished body parts out of the sea, it was the attitude of the government to which we repatriated those remains that troubles me. I still think that is the thing that I am angry about, not that these people drowned, but when we took the body parts and said, 'We found these people', the response was, 'Well, take them back where you found them. They're not wanted here.' So that gave me a view of kind of human life, that every time I think about it, there is a kind of upwelling inside, thinking it ought not to be this way. I would imagine for many people, when they look at the narrative of what they did in Iraq or Afghanistan, for instance—should we have been there, how do I take all of that; and they might think of them as political views—and contain them within a kind of moral self that may have been agitated by what they did or did not do or should or should not have done.

CHAIR: It has been mentioned a couple of times now. Most of the personnel that I have met when I have had the good fortune to travel with the ADF on these excursions they organise for us, they do not think about the social or political views; it is what they are trained to do. They are there for a purpose; they have trained for it; they have succeeded. Because they probably were in a cohort of people who had to train very hard to get deployed. They are in the top of their game, so to speak. What are you seeing when they leave the Defence Force? Do they then consider the social or political aspects of the deployment and that becomes an issue?

Prof. Frame: Yes. I think there are three things. The first one is, before people deploy, do they think about the moral dimensions of what they are going to do? No. Most people do not. When I joined the Navy as a 16-year-old boy, did I think about all the possibilities in front of me? No. This was a career. My dad had been in the Royal

Navy. This is what I wanted to do. Did I think about the possibility of using force or having it used against me? No. Was that seriously countenanced? Well, I served in the '80s when nothing happened. I think most people that I meet, I put to them the moral challenge: would you do this, would you do that? 'Oh, I haven't thought about that. Our job is to implement government policy.' So it seems to me that people in many ways have not dealt with all of the moral components of what they might do before they go.

When they are there, it seems to me that people then cannot but have a view, be it political, be it moral or be it religious, of what they actually find. So they are professionals; they are there to do a job and they will do it well, by and large. But they will still have their own narrative in the back of their head. They will then return home, and as someone said to me recently when I went on a parade, 'Thank you for your service,' they had no idea what I did. They did not know. One wonders if they actually wanted to know. Therefore, perhaps as they look back on when they invaded Iraq in 2003 and look at the carnage that has devastated the country since then, or look at the places we might have gone that we did not go, I think people start to reflect upon those things in a different way, and it is natural that they should do that.

I remember the Vietnam veteran not that long ago telling me that he had a certain view of his service in Vietnam until April 1975 and the country collapsed. Then the way he saw it was quite different, because it then seemed to be in vain. So I do not think it should surprise anyone that people will change their view of what they did with time, and hopefully as they become more mature. But I think what you have observed by and large is true, of people before they go, or perhaps while they are doing it. If you have been to something that will, to some degree, define your life, and is before you are deployed and after you are deployed, then I would suspect you will spend many years reflecting upon that and perhaps changing your view.

Senator WHISH-WILSON: Putting aside the bigger moral issues around deployments and these kinds of things, something that you said did make a lot of sense to me when you talked about emotions such as regret, remorse and shame. My understanding is contemporary veterans, or any veterans, who have experienced the loss of a life of a friend, rather than themselves, for example in a combat situation, often feel that range of emotions, not necessarily related to the moral side of whether or not they have killed someone or taken those actions, but they feel that it should have been them rather than their friend. I can understand that those kinds of moral dilemmas would be there around the loss of a friend or a mate.

Prof. Frame: Yes, life can seem terribly random and, however well you prepare for it: why did the person next to me die and I not die? Then people could say, there is no point and purpose in life, and everything is a bit kind of random.

Senator WHISH-WILSON: The TV celebrity, Peter Cundall, you are probably aware, is a veteran of four armed conflicts. I heard him speak in Launceston recently. He said the thing he still has the most trouble—

CHAIR: Is that the gardener?

Senator WHISH-WILSON: Yes, the gardener, and he does veterans' groups each year, and he takes them gardening because that works very well. He said the thing he still has not come to terms with is the fact that he survived and others did not. That is the thing he most struggles with still, after all these years.

Prof. Frame: It is an integral part of life, and people should not think that it is somehow not part of life. If we are going to send people to do things, that if they did them within Australia would be illegal, when they do them overseas and then return, it is not surprising they will reflect upon that period of time when the normal rules of human conduct in civilised society are suspended.

Senator WHISH-WILSON: Would that possibly be why, taking it to the bigger picture now, Vietnam veterans have seemed as a group to have struggled so much for recognition because they did experience all of these things that we are discussing today in relation to their service, yet they were not necessarily accepted when they got back?

Prof. Frame: I remember in 1969, on Crown Street in Wollongong, Vietnam veterans being booed, and I was nearly in tears, and I was seven. I thought, 'Something is terribly wrong here.' My father, who had been in the Royal Navy and thought the Vietnam War was a bad idea, still felt terribly for these people, because one of the things that are necessary is that when people go off and do things ostensibly on behalf of the country and its people, when they then return, they are at least looking for some acknowledgement. It will come in different forms, but I would think for Vietnam veterans, like that particular day that I witnessed, to be booed, that would have a lasting effect. I was also at a welcome home parade in 1987, and it just seemed to me that I could understand that, when they were beginning to form memories—and memories often are difficult to change—they had certain sensations that they would have felt. If I had come back and been booed, I think just the physical experience of that would have been sufficient to have created a kind of memory that would be hard for me to

overthrow. I would then continue to be angry with people. How come now I am not what I was when I returned? Because life is complicated and moods change. Vietnam is probably the only deployment that we will perhaps ever have where those who wanted the conflict were not the ones who were the subject of the ill will of the community. So Vietnam I would probably put in a separate category.

The difficulty now, I suppose, is that if I could put a broader concept paper, if you contrast 1915 to 2015, in 1915 there was no mood against going to Gallipoli and participating in the First World War. Everything now the ADF pretty well does has some background conflict behind it. There will be a political controversy, and people will have different views about it. I remember one of my chaplains, who was in Kuwait, was saying that some of the people that he was dealing with in Kuwait were saying if what we are doing is so right, how come there are 250,000 people marching in the streets of Melbourne saying this thing is wrong. That then enters into people's narrative about what they did. Really, Vietnam is the first time we had a conflicted war. I think now with all of them, other people have different views about them, and I think it makes a difference to people that they know there is opposition to what they are doing.

Senator WHISH-WILSON: If wars are more conflicted now by nature, politically speaking we should be more careful about politicising them or entering into them, is that what you are saying?

Prof. Frame: No, they are political activities. I think they are inevitably political activities. Maybe it is ADF people are kind of realising as perhaps not before that they are servants of the government. I have had to say to groups of cadets, 'If you thought you joined to defend Australia, well, you did, but you are actually to implement government policy as it is defined and as it is given to you by the government of the day. That is what it is. If you do not care to do that, then now is the time to go.' I wish that there would be more attention to people looking at some of the moral dimensions much earlier in their training so that if they are bidden to do certain things they think are objectionable, we would know early. I say this because I was the speechwriter to the Chief of Navy when Leading Seaman Jones decided in 1990 that he could not go to the first Gulf War. He was on board HMAS *Adelaide*. I wished Leading Seaman Jones had come to that view much earlier than he did, as the ship was about to deploy. We need to know that people who are deploying are kind of one of heart and mind as much as they are able to do this. So it does seem to me that what you are saying is right. The political messages and how they are relayed to people who have to enact the will of the government I think is not an irrelevant factor in people's relationship with the state that they will continue being a citizen of.

CHAIR: Given that we have had this history that you have gone back over, how are we doing in terms of identifying and treating post traumatic stress with this cohort of Afghanistan, Iraq, Timor—do you have any experience or knowledge on that?

Prof. Frame: Just the writing that I have done, say, contrasting the Boer War and the Great War with nowadays. You might say the contrast is too obvious, but it does seem to me that, from both my own experience when I was the Bishop to the Defence Force that we are trying as best we can to give an institutional response—

CHAIR: Are we getting better at it?

Prof. Frame: I would have thought so. Simply the profile that this issue has received means that it cannot be avoided; it has to be dealt with. But what I would say is there is only so much the government can do. To some degree we live lives where we are most influenced by our family and our friends, so my family and my friends should understand what it is that has happened to me. I would contend that in both World Wars, every family was affected in some way and was better acquainted with what had happened, and it was much more frequently spoken about. I would also invite consideration of the commemorative activities in the 1920s with now which had a different tone about them completely. There was almost a sense in which they were national funerals, as people did not have funerals because they were buried where they fell. It also had the effect, I think, of the nation saying to the individual: we have kind of wronged you; we have sent you to something that has damaged you; we feel regret and remorse about that. The dynamics in the '20s were kind of different. I do think that, since Vietnam and the way that particular generation struggled, we have got better. How you put that on a graph and say it is better than five years ago and 10 years ago, I suppose it depends upon the metrics that you would use. What I am kind of observing from a distance as kind of a friend of the ADF is that, in general, there is an attempt to better understand and better manage things. But it will always be with an institution which will always be, to some degree, clumsy.

Senator LAMBIE: You were saying before that you joined up young; and we all join up young. One of your expectations is if you get physically or psychologically hurt that your country will look after you. That is the moral value. That is what you were brought up on. Do you think this is a lot of the problem going on in Veterans' Affairs, that a lot of these people are getting physically and psychologically injured; they are then getting tossed out of the Defence Force like they are second or third-grade citizens, and then they are going in to a compensation

system that is not working for them. What is this doing to their psychological issues? What sort of impact is this having on them psychologically? Let us be honest, when you join up, you expect your country to look after you, and it is not doing its job.

Prof. Frame: Let me speak for myself: when I joined, I realised that there were some things that I might have to do that put a responsibility on me to best prepare myself for them. But yes, I also expected that, in the course of my service, if it was being battered playing rugby against RMC, for which I have broken fingers to show, that I would be looked after if that happened in the course of my duty. That people are tossed out as second and third-class citizens, that is not my observation. I am sure that you meet people who feel that way. I must say that I met *Voyager* survivors of the collision in 1964, and one of the interesting things I found about them was that things that did not happen to them became part of their story and embittered them against people who I think had done them no wrong. The idea that they had survivors leaving and were sent on second-class rail tickets—well, only a very small number did that, but all of them claimed that it was them. I do not want to disagree with you on your view; I am simply saying that my perception is slightly different to yours.

Senator LAMBIE: You were a 16-year-old entry; would you like to see children be able to join our military today at 16 years of age?

Prof. Frame: No.

Senator LAMBIE: Why not?

Prof. Frame: Because I was being obliged to make career decisions when I was still a child. I stayed for 15 years, and I enjoyed it, and I am eternally grateful that I was a naval officer for 15 years. But I think when I joined, it was not an adult decision. I was led to do it by my parents. My father was a violent alcoholic, and I was adopted at birth, so to some degree I was happy to go to get away from my father. I wished I could have stayed at home when I had been there one week. I rang up my dad and said, 'This isn't for me,' He said, 'Fine, you can leave, but you are not coming here.' It was very, very tough. Therefore I do think it better that people should be making adult decisions. Those two years make a difference. I think joining at 16, although I had lots of fun and did lots of interesting things, it left its mark as well.

Senator LAMBIE: Do you believe that children may have been more affected, either for better or worse, during their military service?

Prof. Frame: We did not serve anywhere. No one was deployed before they were 18, so when they were deployed, if you like, they were adults. Of course, the Navy had people from 13-year-old entry until 1956, and the year after my entry, to 15- and 16-year-olds. It was the case we did a lot of our growing up in the Navy, and I think, actually for me, I grew up probably a lot more when I went to the University of New South Wales, because the Navy system then was to send us on campus in Sydney, and I think we integrated better with people, and that was a good thing to happen.

Senator LAMBIE: Okay, so what about those kids that were 15 and joined an apprenticeship scheme. There were between 20,000 and 30,000 children aged 15 who were sworn in to the Army, Navy and the RAAF and served as apprentices. Many of those children during their training were subjected to physical, psychological and sexual abuse while in the care of the Australian Government. What are your feelings on that?

Prof. Frame: We got roughed up. I was 16; we were made to hang from wall bars. We were put up ropes; we got rope burns. We did all of those kinds of things. Do I think that was bad? Yes, I think that was bad. Was I able to cope with it myself? Probably not that well, but there was a group of us who were so affected, and I do think that the kinds of things that happened to us—this is only 35 years ago—if they did happen now, then you would certainly know about it.

Senator LAMBIE: I am not talking about bastardisation; I am talking about sexual abuse. That is what I am talking about. There is a significant difference, and I am sure that you are very aware of that.

Prof. Frame: Yes, but you said other things besides sexual abuse, and I was responding to those things.

Senator LAMBIE: Would you be concerned if the current royal commission examining child abuse in different Australian institutions failed to conduct hearings which examined the abuse of children who served in the Australian military between 1948 and 1993?

Prof. Frame: Why would you separate out those people as an act of policy? I just presume that if you are going to look at children who were abused, then you would look at children wherever they were—

Senator LAMBIE: Because the apprenticeship schemes and that stopped. We stopped taking them at 15 in 1993, that is why.

Prof. Frame: I am not sure of the point you are making.

Senator LAMBIE: I guess my point would be: would you support the call for the current royal commission examining child abuse to conduct hearings which examine the abuse of children who served in the Australian military between 1948 and 1993?

CHAIR: I thought Professor Frame has answered that question. At least, that is my understanding.

Senator WHISH-WILSON: We are getting a little bit outside the terms of reference too, I think, Senator Lambie.

Senator LAMBIE: Well, it is all other matters, I believe, actually.

Senator WHISH-WILSON: No, it is not.

CHAIR: I think Professor Frame has answered it. If he wants to add to his answer, that is up to him.

Prof. Frame: I would say again, I think wherever children are, whatever they are doing, in whoever's care they are, if there is abuse of those children, then that should be investigated.

Senator LAMBIE: Thank you.

Senator WHISH-WILSON: Could I ask a few questions—

CHAIR: Can we just have Senator Xenophon for a couple of minutes. We almost forgot you, Senator Xenophon. That is very hard to do, but we almost did.

Senator XENOPHON: I have a couple of questions for Professor Frame, if I may. I will be as quick as I can. Just following on from Senator Lambie's line of questioning, do you see a distinction in terms of the way you assist and help and support members of the ADF suffering mental health issues from those who, in the ordinary course of their duty, even though what they are subjected to can be quite extraordinary, have suffered a mental harm or trauma and those who have been harmed or suffered mental trauma as a result of something that goes beyond anything that could reasonably be linked to their duties, that is, a case of sexual assault, bastardisation and the like? Do you see a distinction in the way that you would deal with the two? I have spoken to serving personnel in the Navy who have had to pick up body parts in terms of people who have drowned at sea in South-East Asian waters, compared to the 15-year-old lad that was raped at HMAS *Leeuwin*?

Prof. Frame: Yes, I would expect a fundamentally different approach to the two. One of them is in the legitimate course of someone's service, and things have happened. The other are things that are crimes. Therefore it seems to me a different approach. I was not sexually assaulted as a cadet midshipman, but if someone had done that to me, I would regard that as a crime and the way that I would be responded to would be very, very different. I would not have put a political or a social kind of story around that kind of abuse, but I would around a deployment, naturally, because it has a point and a purpose. So yes, I think there is a very different approach to both.

Senator XENOPHON: But in terms of the hurt, obviously there needs to be strong support for both, but insofar as the complaint that I have had to me by victims of sexual assault, for instance, is that they feel that the perpetrators are still in Defence, and their careers were able to flourish while they had to get out because of what happened to them. Do we ensure that there is support for those who have got out of Defence on an ongoing basis? How would you tackle that?

Prof. Frame: I suppose knowing who they are, and that would require to some degree some self-identification of the individuals, I would imagine—I could be mistaken—that if people have been mistreated in those particular ways, there is a responsibility to care for those people and that whatever regimes are available to help them they would be encouraged in that direction. That we did nothing for such people would surprise me.

Senator XENOPHON: I can only talk about some of the people I have spoken to. I just want to go to another issue in the context of the work that I have been doing with Barry Heffernan, a Vietnam veteran, who Senator Fawcett and others on the committee know, who did a lot of good work as an organiser at The Shed in Adelaide, a place where ex-servicemen and women can go and participate as much or as little as they want. One of the issues that he has raised with me to raise with you is: do you think from your knowledge, from your understanding of these issues, that returned servicemen and women should have access, or it is preferable to have access, to psychological and/or psychiatric care from professionals who themselves have a service background? First, do you think that makes any difference to have that sort of empathy, although you do not have to be an ex-serviceperson to have empathy, but do you think that would make a difference? Secondly, what value do you see in the sorts of facilities such as the sort that Barry Heffernan is involved in, in The Shed, where there is a drop-in centre for that mutual support of ex-servicemen and women?

Prof. Frame: I think that empathy is important when you are seeking to assist anyone. If it so happens that you find someone who may have been in your service, in your branch, doing the kinds of things that you have

done, and can speak about it from experience, if you have such a person, and they are a competent therapist and they do their work well, then you are in a very fortunate position. So yes, I would say empathy is important, and if it can be secured, that is good. I would say that the only thing is that the experience offered by the three services is quite different by its nature. So one of the things you might wish to do is encourage people who have served to be the kind of people who are active and care for veterans, people whose service is similar to their own, when they themselves leave ADF service. On the question of the Men's Sheds and things like that, I think they are important places if people, if you like, indulge to refight the war, to talk about it differently, and to talk about it in terms actually that may be more palatable for them in terms of their view of themselves or the moral character of what they did.

Certainly I think events can be told and retold, and I generally find that when people tell the story in a context of not so much reminiscing but trying to make sense of it, those who have empathy—to use that word again—in those circumstances can help people perhaps more accurately come to terms with what happened. In other words, isolated incidents do not become common place. People being down on themselves—you know, I behaved in this particular way, I should have behaved better—well, that is what we all thought at that time. It is to compare and contrast experience through time. I think those kinds of groups where people certainly have empathy community groups, and if it is Vietnam veterans who fight the kind of war that is very different to all others that we have fought, then I think that would be a good thing and I would commend that work.

Senator XENOPHON: Thank you. I will leave it there, thank you, Chair.

CHAIR: Thank you, Senator Xenophon; Senator Whish-Wilson to wrap up.

Senator WHISH-WILSON: We have heard from just about everyone today about the stigma associated with reporting things such as PTSD for service personnel. In your approach where you are perhaps trying to distinguish between the moral injury and other kinds of psychological injuries, such as depression, et cetera, do you think there would be more of a stigma between service personnel wanting to discuss the fact that they may have killed someone or they saw dead bodies—actually, I know one of our submitters spoke on television about seeing a dead Afghan family and what that did to him. Do you think there would be more of a stigma and weakness attached to discussing that kind of thing versus saying, 'Well, I am not fully functioning properly, I am having episodes. I am seeing flashing lights. I am highly strung'?

Prof. Frame: I would not have thought there would be stigma so much, because everyone has an opinion about what they do. The difficulty, I think, that would arise is how do you sponsor that kind of discussion which does not end up sounding like sedition?

Senator WHISH-WILSON: Would that be the sort of thing you would expect to see a chaplain about?

Prof. Frame: I would think so, in certain places. For instance, if it was that we did things we think were morally wrong, then the reason that the ADF has chaplains is to facilitate that kind of conversation. They should be sufficiently skilled to know when and how it can happen. I remember some years ago, though, when I was the Bishop to the Defence Force, a conversation about Iraq going on, and it was almost something that I felt had to be contained, because there were such strong views about the cause, the case, for us being there. It is difficult for serving people to talk about government policy in that way while they are still serving, which implies they have a political view of government policy, which inevitably people do, but it is hard for them to share. But there may be a crossover between a moral view and a political view on something, and how you foster that kind of discussion within a uniformed community seems to be challenging.

Senator WHISH-WILSON: Are you saying to the committee that the two are intricately linked?

Prof. Frame: I would have thought so.

Senator WHISH-WILSON: The moral and the political view?

Prof. Frame: I have been sent to do something politically which has moral consequences for me, because I actually did it. So yes, I am a servant of the government; I will do what I am told, but it was me that had to do it. I am a volunteer, and I could have, at some point, declined to do this, but I did not, and therefore it seems to me that you cannot just say, 'Oh, that is a political thing, that is irrelevant.' People actually have quite strong political views, as you know.

CHAIR: At that point, I think we will thank you very much for your appearance here today and your evidence.

GEDDES, Mr Ryan, Private capacity

POWER, Miss Alanna, Private capacity

WILLS, Mr Ian, Private capacity

[15:54]

CHAIR: I now welcome Ms Alanna Power, Brigadier Ian Wills and Mr Ryan Geddes. Before we go to questions, would you like to make a brief opening statement?

Miss Power: I do not have a speech prepared, but I do have a few points that I would like to bring up.

CHAIR: Okay, well, just relax and go for your life.

Miss Power: In terms of us dealing with DVA, I guess some of the main issues for us was that Ryan went nine months with no income whatsoever. That was while DVA was trying to work out whether they were going to accept liability for his claims.

Senator WHISH-WILSON: Could you start with outlining the circumstances around Ryan's discharge?

Miss Power: Is that not in my submission?

Senator WHISH-WILSON: Yes, if you could read it for the record?

Miss Power: Ryan joined the Army in 2006. He was deployed to Afghanistan as a combat engineer in 2010. He went back again I think it was at the end of 2011, not in a combat role. It was more like a teaching or mentoring position. I think it was 2012 he put in for his discharge. That all went through. He then had work as a landscaper. He discharged on his own; I guess that is the point I should make. He did not discharge for a medical reason or anything like that. It was a choice that he made on his own, despite myself and other people telling him, 'No, you have issues which you probably need to address before you discharge.' But it is really hard to convince them to seek that help. As a result of that, he stayed with Reserves until 2013 when he was finally diagnosed with PTSD, anxiety, depression—all of that. So that was in April. That was when he first contacted DVA. That was when he started going through that claims process of, you know, are they going to accept liability, are they not? Obviously he could not work. He had medical certificates saying that he was not fit for employment in any capacity. But still, we did not get any financial support whatsoever. Once DVA did finally admit liability, which was nine months later, they turned around and said, 'We'll pay him minimum wage', which really is not much, 'until we know if ComSuper is going to recognise his claim and pay out on that.'

We were told by ComSuper it would take six weeks to sort of look at all his medical documents and all of that and make a decision. We were told pretty early on that, with what they already had, it was very likely his claim was going to get denied by ComSuper anyway because ComSuper will not look at any medical documents outside of your full-time employment. Because he was diagnosed with all these issues in Reserves, they said, 'Sorry, we can't look at it; it's the legislation, it is not us.' So I guess that is just how it is.

So it was supposed to take six weeks to get the medical documents. It took nearly five months. When that finally happened, DVA have said, 'Yes, we will pay you the correct rate', which only gives 100 per cent of your wage for 52 weeks, and then after that, with medical documentation, it drops down to 75 per cent. So you have that side of dealing with DVA, which is, I guess, your incapacity payments, they are called, which is like your wage, and the other side of dealing with DVA is also your payout, your compensation. For us, that was probably the hardest part. It is a lot of paperwork to submit. They lose a lot of paperwork. They do not help you in any way. You always have to reach out to them to find out what is happening with your claim, which I think is a bit unfair. You cannot expect someone who is mentally ill to be following up with DVA on a weekly basis to make sure that someone is doing their job properly.

Senator WHISH-WILSON: So you did not have a case officer at all at that time?

Miss Power: No, we did not get one. We did not get a case officer until I think it was two weeks before his claim was finalised. We had already done all the paperwork and everything.

Senator LAMBIE: Do you still have the same case officer, or have you got numerous amounts?

Miss Power: No. Because we have moved, we now have a different one. That was another drama. We told DVA three months before we moved interstate that we were moving, and we needed them to sort someone out for when we arrived. You would think three months is a reasonable time frame. No. A month after we had moved interstate we talked to his former case manager to find out if they had somebody yet. We had been there a month by this time, and they said, 'I have talked to DVA and the paperwork is still sitting on her desk; she has not sent it off.'

Senator LAMBIE: Where are you with your claims now?

Miss Power: Everything we had in has been settled. I guess we do not know whether we are happy with the outcome yet. We are trying to work out whether we want to pursue anything further, but we do not know whether it is worth it, like, just the stress.

Senator LAMBIE: Are you going through an advocate? Is somebody helping you?

Miss Power: Not at the moment, because we just moved.

Senator LAMBIE: So you have been doing this all yourself?

Miss Power: Pretty much.

Senator LAMBIE: Good for you; congratulations. It is very, very difficult, I understand that. So you have not gone to the point where you have used an advocate yet or any legal representation?

Miss Power: No.

Senator LAMBIE: Do you realise what your entitlements are in those areas where it comes to legal aid and things like that?

Miss Power: Not really. We have not really been told anything. So I guess, with that whole process prior to them making a decision about your compensation, you obviously have to send in doctors' reports and they send you out what is called a lifestyle rating questionnaire which, I do not know, it is like DVA tries to put everyone in these neat little boxes and it does not quite work for mental illness. It might be fine for a physical ailment like a back problem or something like that, but then to use the exact same questionnaire for a mental illness, it does not quite cover everything adequately. I guess they get you to fill it out and you do it as honestly as you can, because you like to think you are an honest person, but then when they make their determination, they send you back what they think. It is a rating from 0 to 6, with 6 being the worst. The categories are personal relationships, mobility, recreation, community activities, domestic and employment activities. For us, I think Ryan rated everything between a 5 and 6. When we got the paperwork back, we saw that DVA had downgraded everything to a 4, which to us was a little bit insulting, especially in terms of personal relationships. How does somebody who has never met you, and does not know you, decide no, you are not that fit?

CHAIR: Could I just ask before we go to other senators, in this process which you have articulated, was there at any time an offer of an easier resolution? Did the department ever say, 'Look, if you are not satisfied with our response, you can talk to other people', or did you just completely battle along without any help at all?

Miss Power: No, we did not have any help.

CHAIR: So even when you were asked to fill out forms which you might have found a bit challenging, there was no advice with those forms to say you can seek advice from this area or that area?

Miss Power: No.

Senator LAMBIE: Are you on a Gold card yet?

Miss Power: No.

Senator LAMBIE: Are you on a White card?

Miss Power: Yes.

Senator LAMBIE: So you have done war service?

Mr Geddes: Yes.

Senator LAMBIE: You are not on a Gold card yet?

Mr Geddes: No.

Senator LAMBIE: Fascinating.

Miss Power: I think the only good thing to really come out of DVA is that when we did contact them to say that we need Ryan to see a psyche and all that, straightaway they put that on his White card, but also with a disclaimer saying, 'At this stage we do not accept liability, but you can go see this doctor.' We had already forked out nearly $800 in medical bills for psychologists and psychiatrists before we even got to that stage.

Senator LAMBIE: What did you do for nine months for wages? Were you working, Alanna?

Miss Power: Nothing. I was working, yes. Yes, I picked up extra shifts at work if I could. I think Ryan borrowed $10,000 off his dad, which not many people are in that position where they can just borrow $10,000 off their family, especially if they are people that are supporting children.

Senator LAMBIE: Ryan, was that difficult for you, watching your wife pick up extra hours and you trying to get through your psychological issues by yourself? Are you able to explain?

Mr Geddes: Yes, so much, it was heart-wrenching, especially when they would come home from work and it is just like, you've got the back issues as well, you cannot even stand there long enough to wash the dishes, so she comes home from work and then cleans up and washes the dishes as well. It is just really difficult.

Senator LAMBIE: Do you have other mates out there that are in the same circumstances and going through the same thing as you two are going through?

Mr Geddes: And worse.

Miss Power: There are people in a much worse situation than we are, especially the guys out there who have kids to look after as well. A lot of partners have to go out and work 40-plus hours every single week, then come home and do all the housework and look after the kids on their own, because their partner not only has the mental issues, they also have physical problems as well. So, for Ryan, it is his back. It is just hard.

Senator LAMBIE: Have you had many of your mates that have lost partners going through this, Ryan?

Mr Geddes: Most of them.

Senator LAMBIE: Okay.

Senator WHISH-WILSON: Ms Power, you are doing a fantastic job, by the way. If either you or Ryan do not want to answer these questions, do not feel obliged to. But I am really interested in giving the evidence we have heard today about service personnel who are about to go, why there is a stigma attached to, I suppose, self-identifying with issues. I wanted to ask Ryan if you knew there was an issue at the time and you did not want to self-identify because of reasons?

Mr Wills: I am a bit disturbed. I would prefer questions be directed to Alanna. We do not want to put Ryan under stress, and he is here to accompany Alanna. If you would not mind.

Senator WHISH-WILSON: Absolutely.

Mr Geddes: I do not mind answering one. Can you ask the question again?

Senator WHISH-WILSON: I was just interested at the time you were discharging, you did not go for a medical discharge. Were you aware that things were not right, or did this occur? Did you sort of know further down the track?

Mr Geddes: I knew that there was something wrong. I did not know what it was. I was angry. I was drinking a lot, and I was taking a lot of it out on Alanna. Yes, I did know that there was something there, but I did not want to admit to it because you are in a position of power; you are in charge of people, people are looking up to you. You do not want to be seen as somebody who can succumb to something like that. For me back then it was—

Senator WHISH-WILSON: Seen as a kind of weakness, I suppose?

Mr Geddes: It was a weakness, and up until early this year I still thought of it as a weakness. Until all my friends told me, my partner told me, my parents told me, and I just told them to get you know, that I was fine. I did not want to process; I did not want to go through that way because I wanted to still be able to work. I thought if I do say anything about this, then that is me, I am never going to be able to get a job doing what I want to do again.

Senator WHISH-WILSON: Thank you for sharing that. That is very important. I will direct the question to Alanna, but do you feel that, amongst your network, there is more of an acceptance now around this issue, or is there still a stigma attached to it?

Miss Power: It is hard to say because everybody we know who has been diagnosed with mental issues and is struggling, most of them have already discharged.

Mr Geddes: So a lot of the guys actually go through and discharge themselves. It does have a lot to do with that stigma as well. They do not want to have that on their shoulders, that they are sick. They want to be able to get out and do work again.

Senator WHISH-WILSON: Start a new life.

Mr Geddes: Do something that matters again.

Miss Power: It is also like people cannot see the illness, when you have mental illness. If you are having a bad day or something, people might not understand. They are, like, what is wrong with you?

Senator WHISH-WILSON: We heard from a group today who were the Australian Families of the Military Research and Support Foundation who were a fantastic group who come into Canberra quite a lot and talk to us.

If families had been involved in the process around discharge, things might have been a bit different, because they do see the symptoms and signs, and they understand sometimes better than the soon-to-be vets do. Do you agree with that?

Miss Power: Yes, definitely.

Senator WHISH-WILSON: Have you had any discussions with this group at all about your situation?

Miss Power: No.

Senator FAWCETT: If you had been given that opportunity to be involved in the whole discharge process, even though it was voluntary, is that something that you would have taken up?

Miss Power: Yes, I think so, definitely.

Senator FAWCETT: You have made the comment in your submission, on one of the positive notes there, that the case worker you have had from DVA has been fantastic.

Miss Power: Yes, when we finally got them.

Senator FAWCETT: Sure. If from the first point you contacted DVA you had been given a case worker, even though they had not accepted liability and all the rest of it, would that have made things easier from your perspective?

Miss Power: Yes, I think so, because you would have had a better idea of what to expect. We got most of our information really when Ryan went to Toowong to do that PTSD program with Dr Khoo. That is all group work, so you are in a small group of I think five or six veterans. They do an intensive four-days-a-week program over six weeks. For three of those weeks the partners get to come in for two of those days and they do specific things with the partners. You do things together with the veterans, and it is just really good. Most of my information came from the other ladies who were there. They had pretty much already been through what we were going through. So, through talking to them, that is sort of how we got to know what to expect, especially in terms of dealing with DVA. We did not quite believe them at first, and they said that when you do a DVA-ComSuper, it can take over a year. I was, like, surely not. But yes, sure enough.

Senator FAWCETT: During Ryan's period with both the regular forces and the Reserve, did you have any interaction with DCO at all—Defence Community Organisation?

Miss Power: No.

Senator FAWCETT: Were there any support groups of partners or spouses of members of the regiment that you connected with, either on Facebook or physically through social functions?

Miss Power: No, just the friends we already had, I guess.

Senator FAWCETT: So if you wanted to reach out, like when you started noticing symptoms, would you have naturally gone to somewhere like beyondblue to look for information? Was there somewhere within Defence that you knew was somewhere you could go to, or is that all a bit of a mystery?

Miss Power: No, I did not know anything like that was really available. But if I had, maybe, yes, maybe not. Something like beyondblue, I guess I would probably prefer to talk to someone more like myself who is going through it, or has already gone through the process.

Senator FAWCETT: If Defence were going to try to put something in place so that someone in your situation in two years' time could easily access information, how do you think they best could achieve that?

Miss Power: I guess it is hard, because everybody has different ways of accessing information, and utilising that information. For some people, they are quite happy to just go to a website and access that information, or they are quite happy to just subscribe to maybe an e-newsletter or something like that that has basic information and whatever else, whereas other people will not do that; they would prefer to have face-to-face contact with someone and be able to actually talk to someone.

Senator FAWCETT: When you were posted to Enoggera, for example, if you as a recognised partner got a letter saying, hey, there is a social worker based at Enoggera and here are the contact details, feel free to call if you ever need to, would that be something you would have followed up through this process?

Miss Power: Yes, I think so.

Mr Geddes: Could I add something?

Senator WHISH-WILSON: Yes.

Mr Geddes: Also, obviously when we get deployed, there are spouse packs that come out and tell you—they say, 'Oh yes, your partner may come home angry,' and things like that.

Miss Power: Yes, I remember getting that.

Mr Geddes: But it is not really adequate.

Miss Power: You do not look at it.

Mr Geddes: From my point of view, there needs to be something where the partners can do a course or have something like that where they can actually see the symptoms, they know what to pick up on and all that sort of stuff. A tiny little pamphlet does not really cut the mustard.

Miss Power: I think for me the best thing that I have done is the Toowong program. Even just after the first day of being there, you get told all about PTSD, what it is, what the symptoms are, why your partner is behaving in a specific way, and it just sort of all clicks. It is like, I get it, I get it now.

Mr Geddes: That was four years too late.

Miss Power: Yes, it is too late. It is having that understanding.

CHAIR: Sorry to cut you off, but before I lose this trend, when you were dealing with the department—and I take it that you were doing most of the filling out of the paperwork—did you get officially recognised for doing that, or were you doing that on behalf of Ryan? Did they accept the fact that you were filling out the paperwork, and that you were the only one that could basically do that? Were you officially part of the process, or were you doing it unofficially?

Miss Power: They never asked, but when we filled out the forms and stuff, I would write a little thing down the bottom to say I had filled this out on behalf of Ryan Geddes, only because we did not want them to look at it and be, like, oh, your partner has filled this out; you did not fill it out. We were not sure.

CHAIR: Did that have any impact on the timeliness of their response?

Miss Power: Not that I am aware of.

CHAIR: It was tardy, but was that one of the reasons why it was not acted on as efficiently as it perhaps could have been?

Miss Power: I do not think so. I think DVA is just severely under-resourced and understaffed, and the staff that are there, some of them plainly just do not know what they are doing.

Senator WHISH-WILSON: You do not think they were deliberately trying to put up blocks?

Miss Power: That is a really big accusation. I do not know.

Senator LAMBIE: You can pass it over to an advocate or you can pass it over to your wife, or you can pass it over to me in my office, and we will get the job done for you. That is how it works.

Miss Power: Yes, it is not easy. I have tried calling them before and you get like a specific number to deal with things like case files, and sometimes that number would just ring out or you would get a voice message saying so and so is not available. So then you try and just call up the regular number and try to get information that way. A lot of those staff either do not have access to the information that you want or they give you information which is incorrect.

Senator FAWCETT: Can I come back to the passage of information? When the regiment deployed, prior to deployment, was there a function? I am thinking 7RAR, for example, have families come in and there is a big barbeque, et cetera, and then also while people are away, some units have ongoing functions where families can come and get information. Did that sort of thing occur, and were briefs provided of things like PTSD and some of that information?

Miss Power: I do not really think so. I just remember getting a little bit of information in the mail saying that Ryan is going to be deployed, this is where he is going and whatever else, and then also that DCO would check in. I think I got a few voice messages from them, but honestly, at that point, I was not really thinking about it. I did not think about it.

Senator FAWCETT: Given that you were not thinking about it, because you had not experienced it yet, if that opportunity had been provided, how could they have encouraged you or attracted you to actually go and take an evening or an afternoon of your time to hear somebody talk about that?

Miss Power: I do not know. I guess they would have to get somebody relatable sort of advertising that. If I just got a phone call from some random person saying, 'Oh, you can come to this', I would say, 'I have better things to do.' That sounds really harsh, but knowing what I know now, I would jump at the chance. When you do not have that knowledge, you just do not think about it. You really do not.

Senator FAWCETT: That is pretty normal, but understandable.

Senator LAMBIE: What is your dog's name?

Mr Geddes: Yogi Bear.

Senator LAMBIE: How long have you had Yogi Bear?

Mr Geddes: Five years and three months.

Senator LAMBIE: Has he come from Whiskey's?

Mr Geddes: Yes, Whiskey's Wish.

Senator LAMBIE: Okay. They are pretty cool, those blokes, aren't they? I just wanted to say it is really brave of you guys. You are doing a great job, and I know there are a lot of partners out there who are holding everything up. I salute you, and Ryan. Just keep trying to get better, because I know it is really, really difficult, but do not give up faith. You have a future, and you will come out of this, you really, really will. So just keep on soldiering on, mate. It is one step at a time. Okay? You should be very proud of yourself, and thank you for coming forward. It is very difficult to do; we understand that.

Mr Geddes: Thank you.

Senator WHISH-WILSON: I will just add that there are probably people right around the country listening to your story today, so thank you for being brave and sharing it. It will make a difference.

Miss Power: Thanks.

CHAIR: Thank you very much for your evidence and appearance here today. That concludes the public hearing.

Committee adjourned at 16:20