DFWA Qld Branch Submission
Senate Committee Inquiry into Suicide by Veterans and Ex-Service Personnel

1. The Defence Force Welfare Association, Queensland Branch Inc welcomes this opportunity to make a submission to the subject Inquiry by the Senate Foreign Affairs, Defence and Trade Committee. This submission will primarily focus on TOR **a**, but the range of matters discussed will also relate to TOR **c, e** and **f**.

Definition

2. There is often confusion in the minds of many people as to what constitutes a **veteran**. For clarification and ease of reference in this submission **the term Veteran is used to refer to a person who is serving or has served in the ADF with or without operational service**. The Inquiry might also like to consider using the term Veteran in the same context.

3. All entrants to the ADF make an oath of service, giving up certain human rights enjoyed by all other Australians. The ADF exists to carry out the will of Government in a violent environment and training of ADF members aims to replicate that environment. From the outset, ADF members are deliberately exposed to violence and are trained to react and continue working in stressful and often dangerous situations. Over many years, there have been numerous major and minor accidents where ADF members have been injured and/or killed on duty whilst training for war. The training environment stressors can have a deleterious effect on the mental health of individuals whether or not they make it through the training program, and this may be a contributing factor in some suicidal events.

Veteran Suicide Identification

4. TOR **a** seeks to understand the reasons why Australian Veterans are committing suicide at a high rate. This understanding should ideally be informed by a thorough examination of a large sample of case studies, but therein lies a problem. At present, with the exception of Veterans still serving, there are no official means to identify if a suicide victim is a Veteran. Identification of Veteran suicides and the statistics provided, currently depend on the efforts of Ex Service Organisations (ESO), assisted by friends and family members notifying the Veteran network. Many Veterans, especially those who have "dropped-out" of society, or withdrawn from family and friends, i.e. those most vulnerable, may not have been identified as Veterans. **It is reasonable to conclude that the number of Veteran suicides is most likely under-reported.**

5. Unless there is a mechanism established to routinely identify Veteran suicides and suicide rates, it will be difficult to measure with a degree of confidence the success or otherwise of current and future interventions. However, reporting and investigation of suicides are responsibilities of State Coroners. There is currently no particular

requirement for Coroners to identify suicide victims as Veterans when appropriate. Whilst the ADF records suicides of serving members, no organisation is responsible for recording all Veteran suicide statistics.

Factors Contributing to Veteran Suicides

6. The ADF selection process includes psychological testing to identify those with existing mental disorders or an unacceptable potential for developing mental health conditions. Additionally, during initial training, candidates exhibiting a lack of resilience to stress are screened out. As a result, ADF personnel should be more resilient to stress and less likely to succumb to mental health issues which could lead to suicide, than the general population. It is an unambiguous fact that as a sub-set of the broader population, ADF members have significantly higher standard of mental fitness. It follows that, other things being equal, the suicide rate for Veterans should be significantly lower than for the general population. However, something/s during their period of service or afterwards cause a number of Veterans to take the tragic decision to end their lives.

7. Some of our DFWA(Qld) Pension/Welfare Officers and Advocates have had Veteran colleagues who have tragically taken their lives. Traumatic events during ADF service may have been contributing factors for some whilst additional stressors after their ADF service may have contributed to others. We are also aware that some of our colleagues have lost children and spouses to suicide raising the question whether or not the Veteran's mental health had been a contributing factor to theses suicides – in much the same way as Agent Orange has affected Veteran children. However, this is a matter beyond the TOR. Nevertheless, it is clear that **acquired mental health conditions such as anxiety and depression are often a precursor to suicide or attempted suicide, and any additional stress on an individual with an existing mental disorder could reasonably be expected to further aggravate the mental health condition and potentially increase the risk of a suicidal event.**

8. Dealing with bureaucracies to address personal, medical and financial issues can be stressful for any individual when they are confronted with a large process-driven organisation that treats their personal matter in a routine and impersonal way. DFWA (QLD) has supported thousands of Veterans and their families over the years, dealing with DVA, ComSuper, CSA and other government agencies through our Pension Officers and Advocates appointed by the Veteran or family as an Authorised Representative. This system significantly reduces the stress on the Veteran. A common comment has been "I could not have gone through with the claim or the psychiatrist appointment without your support". **It is reasonable to conclude that Pension Officers and Advocates of ESOs assist in reducing the stress experienced by Veterans who engage with DVA and other government agencies.**

9. While some stress in dealing with government agencies is to be expected, DFWA (QLD) has had many experiences where DVA in particular has created unnecessary, frequent and severe "stress incidents" directly attributable to Departmental practices. These "stress incidents" accumulate in the fragile mind of the Veteran causing further aggravation/deterioration of their mental state. The effects can and do snowball with serious consequences. We are aware of other veterans who simply give up the pursuit of their entitlements to compensation and rehabilitation because the often adversarial nature of the ongoing claims process risks further damage to their mental health.

Lingchi - Death by a Thousand Cuts (lots of small bad things are happening, none of which are fatal in themselves)…

10. There are numerous cases that exemplify the stressful nature of Veterans' interaction with DVA. Incredibly, in some cases, the DVA process has resulted in deterioration of the very condition that the Veteran is claiming and for which DVA has a responsibility to provide rehabilitation. The Veteran Case Study at Attachment 1 is an indicative example is chronicled in and is summarised below:

- The Veteran claim has taken over 18 months so far and it remains unresolved. Some of the delays can be attributed to inability to get medical appointments, slowness of doctors' report writing, responding to DVA requirements and the Veteran not keeping appointments and not responding to DVA requests for documentation.

- However, the delays due to lack of Veteran response are due exclusively to DVA contacting the Veteran direct and not using the Veteran's Authorised Representative (AR). This happened on at least 6 occasions in this example. It appears that DVA staff lacked visibility of the Veteran file due to its physical location interstate and inadequate IT support.

- The administration of the Veteran's claims has been hampered by the different Acts covering his rehabilitation and compensation which are supported by three different business processes and supporting organisations. Within MRCA there appears to be 3 separate organisational Parts handling different aspects of Veteran support. In communicating with MRCA Parts A, B and C, the AR found that each area was unaware of what was being done in other areas and the impact on their area and the Veteran. Staff were not aware of medical reports on file related to the same condition and answered the same questions that had been asked in reports commissioned by other parts of DVA. The *stovepiped* IT systems hindered the flow of relevant Veteran data between the staff processing his claim. All of these deficiencies have contributed to the delay experienced with the Veteran's claim and additional stress placed on the Veteran.

- The three separate Acts and three separate business processes and support organisations coupled with a lack of effective IT support have made smooth administration of the Veteran's claim impossible. The example clearly shows the adverse impact on the health and wellbeing of the Veteran and his rehabilitation. How much closer is this Veteran going to be *pushed towards the edge* before his claim is resolved?

Conclusions

11. More reliable data is required to better understand the reasons for Veteran suicide and measure the effectiveness of intervention programs over time.

12. The 3 separate Acts covering the compensation and rehabilitation of Veterans introduce an unnecessary level of complexity and cause excessive delays and additional costs in administration - all of which is to the detriment of Veterans' financial and mental wellbeing.

13. The splitting of functions geographically without appropriate IT support means DVA staff lack appreciation of the total picture regarding a Veteran's case. This further adds to delays in processing, duplication in actions required to resolve claims and additional frustration and stress for the Veteran.

14. Current business practices add stress to vulnerable Veterans and aggravate mental health conditions which adversely impacts their rehabilitation and increases the risk of some Veterans engaging in a suicidal event.

Recommendations

1. For the purpose of the Inquiry, the term **Veteran** should be used to refer to a person who is serving or has served in the ADF with or without operational service.

2. DoD and DVA together should:
   a. Make arrangements with States for Coroners, for all suicides, violent and referred deaths to:
      (1) Identify if the deceased had served in the ADF;
      (2) Examine the medical and service record from DoD and DVA to identify any causal relationship between ADF service and ADF/DVA medical history and the suicide.

   b. Make arrangements whereby Coroners can readily determine from the ADF if a person had ADF service.

c. Make available Service and Medical records when requested by State Coroners.

d. Require DVA to establish procedures with the States and the ADF to provide a central record of Veteran suicides.

3. The Government should replace the current mess of legislation with a single Act based on the VEA to provide compensation and rehabilitation services for all entitled Veterans.

4. The Repatriation Commission should further increase the range of automatic liability conditions that can be claimed for Service related injuries and illness to reduce processing costs and claim processing times.

5. DVA should streamline business practices by introducing 21st century claim processes using online technology.

6. The Government should place higher priority (with immediate full funding) to completely upgrade the deficient IT systems that are the root cause of many of the administrative problems faced by Veterans in pursuing their claims.

7. DVA should improve the level of staff training with an emphasis on an empathetic rather than adversarial approach to client relations and consistency in decision making.

8. DVA should adopt a policy of recruiting suitably qualified Veterans to fill a quota of available staff positions in keeping with the spirit of Minister Teehan's August 16 proposal for the employment of former ADF members. This initiative would help engender clearer understanding within DVA frontline staff of the military client base and culture.

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Attachment:
1. Veteran Case Study.

ATTACHMENT 1

Veteran Case Study

Ser	Event	Veteran Impact	Mnth
1.	Authorised Representative (AR) nominated and contact details provided in initial paperwork for Disability.		0
2.	AR arranges GP appointment with Veteran for completion of Non-Liability Claim and psych referral.	Veteran attends appointment	
3.	Paperwork also submitted for Non-Liability Claim.		
4.	AR contacts DVA re Claim (mid Jun). DVA advised claim received but being held until after end of Financial Year.		2
5.	DVA communicates with Veteran direct regarding medical appointments and Proof of Identity and does not advise AR.	**Veteran stresses out** regarding medical appointment and work clash. Ignores request for Proof of Identity. Veteran unilaterally stops job. Employers concerned. **Contact Police who do Welfare Check.**	2
6.	AR contacts DVA re progress of claim. Advised of requests and advice sent to Veteran.	AR contacts Veteran. Situation assessed. Veteran calmed.	3
7.	AR advises DVA not to contact Veteran and that appointment needs change. AR advised DVA records this on file.	AR advises Veteran of new appointment times.	3
8.	AR accompanies Veteran to medical appointments.	Some appointments cancelled. Veteran unable to handle more than one appointment a week. Unfit to drive or use public transport after psychiatric sessions.	3-6

Ser	Event	Veteran Impact	Mnth
9.	After 8 months and 3 months psychiatric assessment, several medical reports, liability accepted for several disabilities including PTSD and substance abuse.	Psychiatrist advises Veteran not yet ready for some treatment and referred to psychologist counsellor. Veteran more relaxed with counsellor.	8
10.	DVA advise claim for some disabilities passed from VEA to MRCS and SCRA.	AR arranges for Veteran to give consent.	10
11.	AR contacts MRCA staff. They advise file not yet received from VEA part.	AR advised Veteran. **Veteran anxious**. Financial difficulty.	11
12.	MRCA staff (A) contact Veteran direct advising that claim is deficient and further documentation and proof is required.	Veteran does not understand and tells DVA to contact AR. DVA staff advise that they were aware of AR. **Veteran stressed, relapses, ceases all medical treatment, including ceasing medication for a life threatening disease.** Does not tell AR.	13
13.	MRCA staff (A) contact AR and explain requirements. AR advise MRCA staff (A) not to contact Veteran direct. Only time AR had experienced abrupt and off-hand treatment by DVA staff.	AR advises Veteran issues with DVA being addressed. Advised to ignore the rough speaking he received from DVA staff.	13
14.	MRCA staff (C) contact Veteran direct advising that 2 other conditions claimed will be dropped from claim as Veteran has not provided information or medical evidence,	AR manages to contact Veteran. Discusses situation of most issues.	14
15.	AR contacts MRCA staff(C) regarding 2 other conditions. Reiterates do not contact Veteran direct. MRCA staff (C) advise conditions regarded as new claims. AR advises these conditions not new but were on original VEA claim.	AR updates Veteran.	14

Ser	Event	Veteran Impact	Mnth
16.	Several AR calls to MRCA staff (C) to resolve. Claims will not be considered unless information provided within 48 hours as Veteran has had plenty of time to respond. AR advises Veteran not in position to respond. . Requires GP referrals, appointments for Xrays etc. AR negotiates with DVA staff.	Veteran not advised by AR of "tough" tone adopted by DVA. (Suspect dropping of 2 claims would affect resolution rate **KPIs of** MRCA section.)	
17.	MRCA staff (B) notify Veteran direct of 3 new medical appointments with specialists and GP to report on already accepted disabilities.	**Veteran freaks out.** Contacts AR. Refuses to see new psychiatrist – "I'm not going through all that again". **Refuses contact with anyone**.	15
18.	AR contacts MRCA staff (B). • They have no details of AR appointment on IT system they use. AR requests escalation to resolve and ensure Veteran not contacted direct. DVA record AR details over the phone and put on system. • They have no record of previous medical reports from psychiatrist, surgeon or GP. They are not on file and do not exist. AR advises reports must exist because DVA have accepted liability. DVA staff advise that VEA reports do not address MRCA requirements. AR requests MRCA staff forward details of medical appointments and reports required	AR unable to contact Veteran.	15
19.	DVA forward details of new requirements as requested. AR advises MRCA staff (B) that he has copy of the VEA reports from DVA following an FOI request and new reports required are almost identical to those under VEA. MRCA staff advise they have not seen reports and will get copy of Veteran file from Melbourne.	AR unable to speak with Veteran. Leaves messages to effect that DVA issues are being sorted.	15

Ser	Event	Veteran Impact	Mnth
20.	DVA MRCA staff contact AR and forward new document to appoint AR.	AR still unable to contact Veteran. **Police called to conduct Welfare check.** Contact made. AR attempts to calm Veteran. Veteran signs new AR form. AR forwards AR Appointment form. **AR discovers Veteran has ceased medical treatments. Veteran agrees to resume medical treatment,**	15
21.	Veteran sees GP for new report regarding new conditions and new referrals for treatment. GP certifies continuation of mental health problems and unfitness to work.	**Veteran stressed** after GP appointment. Veteran fails to keep new appointment with orthopaedic specialist in same week.	
22.	AR requests MRCA staff (B) to accept VEA reports from psychiatrist and orthopaedic surgeon previously made to DVA.	AR advises Veteran. Veteran refuses any more medical examinations.	17
23.	AR requests MRCA staff (A) to accept Medical certificates of inability to work from GP		18
24.	AR requests DVA advise progress of claim. Do not yet know if MRCA sections have accepted the VEA commissioned psychiatrist report asking same questions as it is over 6 months old.		18