PRODUCTIVITY COMMISSION DRAFT REPORT

A Better Way to Support Veterans

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I welcome the draft report produced by the Productivity Commission *A Better Way to Support Veterans*. The draft report is comprehensive and offers insight and avenues for much required reform. Whilst many may view the reforms as going too far, I argue that, for the contemporary veteran, many reforms do not go far enough. To make the system fit for purpose now and into the future any reform must be a holistic total systems approach including reforms within the Department of Defence, specifically the ADF – not just DVA; DVA inherits many complexities from the ADF.

A strong capability equates to a strong ADF. Supporting the welfare of personnel significantly strengthens ADF capabilities. Where the ADF has historically been progressive and contributed to significant change in wider society, it has arguably fallen behind current societal change and progress. Review and reform creates an opportunity for the ADF to again become leaders within society. Any reform requires strong incentives to ensure transparency, accountability and the welfare of its personnel at all stages of a member's military engagement and beyond. To not do so offers a very real risk of future and increased harm to veterans and their families which inevitable will create further burdens and costs on the system. It will create a system that is perpetually 'not fit for purpose'.

Section one of this submission is to assist the Commission in making an informed decision through robust and independent critique and research. Section two offers responses to Draft findings, recommendations and information requests, and Section Three considers alternative models. I urge the Commission to seriously consider this information and conduct further inquiry and analysis before reaching its final conclusions.

Section One: Understanding the terrain

1.1 Introduction

Section one of this submission is to assist the Commission in making an informed decision through robust and independent critique and highlighting root causes which are often misunderstood, misinterpreted, or hidden. It will do this by offering research within areas that have not been actively explored by the Productivity Commission, but which are vital components in understanding the nature of contemporary service and how such service fundamentally affects outcomes for veterans.

1.2 Contemporary Service

Contemporary service is about a professional occupation within an institutional environment; a public institution that serves the Australian people (Wadham and Morris 2019). The combination of profession, institution, and service is what makes contemporary service unique, and different, to previous service eras and veteran cohorts. In Australia, contemporary service is not characterised by conscription or national service but by a professional occupation within a public institutional setting. Contemporary service is more about a career which requires a continual readiness for deployment as opposed to the popular narrative which singularly views service through the lens of 'returning from war' and 'sacrifice of life on behalf of the nation'. This does not suggest that, within the contemporary setting, sacrifice of life is not a daily reality for the minority of personnel deployed into, or in direct support of, active combat positions. Nor that the potential of sacrifice is not intrinsic to service. What it does suggest is that currently there is much confusion and even less understanding of the differences between contemporary service as opposed to the service eras that have come before. This confusion has increasingly led to poorly targeted policy and supports, for both serving and ex-serving personnel and their families, which not only contributes to poor outcomes for individuals but also places a greater financial burden on both government departments and community sectors.

Contemporary service is predominately characterised by unremitting training regimes within an everyday work environment. For some personnel, training will demand that they engage in complex high-stakes decision making which carries with it an inherent risk of physical injury or death. Contemporary service is also significantly influenced by military culture and institutionalisation. Recent investigations have studied the effects of diminished agency and unrelenting training regimes within the military institution (Howell 2010; Gallagher 2016; Senecal and Macdonald 2017; Molendijk, Kraner, Verweij 2015, Wadham and Morris 2019). The findings of this research suggest that it is regimented systems of governance, which contributes to, and exacerbates, poor outcomes for veterans. This is increasingly becoming a benchmark for understanding the effects of contemporary service.

In terms of contemporary service, whilst some personnel may deploy into war/warlike or peacekeeping zones, some multiple times, others may not. Notably, contemporary conflict has become rationalised and privatised with both state and non-state actors involved and working within conflict zones; conflict zones have, in many instances, become professionalised work spaces. This shifts the parameters of what it means to deploy. Understanding the different tasks and locations of workplaces within contemporary conflict zones is integral to properly targeting policy and understanding contemporary service. Often it is those deployed in active combat positions, or in direct support of such positions, who carry the heaviest burden by being expected to transgress moral and societal norms in relation to the sanctity of life. This burden separates active combat personnel from other contemporary veterans, including other personnel who have deployed. Whilst atrocities witnessed across various deployment settings should not be minimalised and should be duly recognised, it is the intentional transgression of life which sets combat veterans, and those in direct support of combat positions, apart. In sum, irrespective of deployment status, everyday contemporary military experiences, shaped by the military's capability functions, can be physically and psychologically demanding and, along with positive associations and pride in service, can bring negative impacts on long term physical and mental health for those serving and their families; it is the everydayness of contemporary service which significantly affects many personnel. Understanding contemporary service and the differences between contemporary service and previous

service eras is vital for building and sustaining contemporary ADF capabilities and a system for veterans and their families which will be fit for purpose now and into the future.

1.3 Institution vs Occupation

Post occupation Australian military service has its beginnings with the Australian and New Zealand Army Corps (ANZAC) in WW1. Many veterans up to the Vietnam War were national servicemen; either civilian volunteers or conscripts. However, by 1976, conscription had been abolished and the three separate branches of the Army, Navy, and Air Force had been unified under Tange's Defence Diarchy. The *Defence of Australia* Act in 2001 (Horner, 2001) further centralised ADF organisational structure built upon the premise of a career orientated volunteer force. This ongoing shift from institution to occupation significantly changes the military experience and shifts the understanding of service from 'returning from war' to 'readiness to deploy'. Arguably, this shift makes personnel become more insulated from civil society as the ADF emphasises everyday occupation over institution and sacrifice for the nation:

> *An institution is legitimated in terms of values and norms, i.e. a purpose transcending individual self interest in favour of a presume higher good … An occupation is legitimated in terms of the marketplace, i.e. prevailing monetary rewards for equivalent competencies (Moskos, 1977: 42-3).*

The principle interest being that there is, and has been, a significant change in relations between civil society and the military. In today's military, individuals take up an occupation in a highly institutionalised workplace, one that sees them separated from an increasingly individualised world (Wadham and Morris 2019). Hence, the ADF manifests an expression of both institution and occupation.

The dual structure of the ADF as both organisation and institution means that its members are not simply employees but are considered appendices to the state (Mumford 2012). The way in which the ADF abrogates individual agency and certain liberties from its members means that there is a quantifiable need for the Australian government to provide care and support for them and their family. Historically, this special contribution from service personnel has reflected their unique 'contract of unlimited liability' with the state in reference to war; a contract that necessitates potential sacrifice of life, and abrogation of individual liberties, for the sake of sovereign and nation. Whilst the parameters of this contract have arguably shifted within the contemporary ADF environment, the essence of the contract retains relevance because, within the institutional setting, personnel still sacrifice their individual agency and sacrifice of life still occurs (Howell 2010; Gallagher 2016; Senecal and Macdonald 2017; Molendijk, Kraner, Verweij 2015).

The regimented structure of the ADF which constrains individual agency creates a climate in which individual human/workers/civil rights violations can more readily occur and abuse/misuse of power becomes systemic. Arguably, within the contemporary setting, injury or trauma experienced is not the entirety of the issue, it is also the way that personnel are managed, or mismanaged, within an institutionalised workplace which contributes to poor veteran outcomes. Therefore, any new system proposed by the Productivity Commission should consider how to proactively support veterans and their families within an institutionalised setting. A system that supports veterans and their families within an institutionalised workplace will arguably lead to better veteran outcomes and, therefore, build a stronger ADF capability and sustainable workforce. In order to accomplish this, it is important to understand the forces which shape the contemporary ADF and the systemic limitations which are contributing to poor outcomes within the system.

1.4 The Contemporary ADF Environment

1.4.1 Functional vs Societal

The ADF is shaped by two forces: a functional (capability) imperative stemming from the threats to security and a societal imperative arising from the social forces, ideologies, and institutions dominant within Australia (Gabriel 1982). This is the core tension of military/civil relations. How to appropriately balance these competing forces is arguably the base consideration that requires constant consultation and deliberation for the Department of Defence.

Hierarchal structure is an expression of the functional imperative in military life (Woodward and Jenkins 2017). Its manifestations create tensions between a military requiring the full and complete commitment of personnel, and civil society which requires the military to remain connected to the society from which it is drawn. These manifestations become embodied within individuals who serve in the military. As Gard (cited in Gabriel 1982) explains;

> *Military organisation is: hierarchal, not egalitarian, and it orientated to the group rather than the individual; it stresses discipline and obedience, not freedom of expression; it depends on confidence and trust, not caveat emptor; it requires immediate decisions and direct action, not thorough analysis and extensive debate; it relies on training, simplification and predictable behaviour; not education, sophistication and empiricism*

The core business of militaries means that there is a necessary requirement to prioritise functional imperatives over the welfare of individual members. Whilst this area of inquiry is well debated and critiqued, it is a structural reality (continual tensions between military/civil imperatives). This does not suggest that the ADF does not support the welfare of its members, simply that, given the structure and competing forces within the institution, the institution requires capability to come first. The simplicity of this binary becomes complicated because members of the ADF are, in fact, the integral component for effective and sustainable capability. By properly acknowledging the principle business of the ADF and competing agendas and forces, well informed policy and systems can be designed to protect and ensure the wellbeing of members whose individual agency is diminished as a requirement for capability - potentially striking a workable balance between the function and social imperatives of the ADF.

1.4.2 Military Socialisation

As a functional imperative, military socialisation is a requirement for capability and is executed with the purpose of creating a collective (Moore 2009). It is a core part of sustaining military subjectivity and functional imperatives through conformity and strict hierarchy. At enlistment, the process of militarisation begins. When an individual enters the military environment, they undergo particular routines of self-mortification (Goffman 1961). Military historian Darren Moore (2009: 75) explains:

> *The objective is to purge the recruit's civil identity, including any preconceptions he may hold about his rights and personal freedoms, and supplant the civilian value system with that of the military. This is accomplished by various methods, including denigrating those outside the military system and at the same time stressing the virtues of military community; it is in effect a transformational approach where the recruit self-actualises the desire to become part of the military. Other approaches are more individualized, relying on humiliation (including feminization of the male recruits) and brutality to break an individual's self-esteem, lower their resistance to the values and attitudes that the military wants them to adopt, and reinforce the omnipotent nature of military discipline.*

Military socialisation internalises military power configurations and the intensely hierarchal culture of the military. Bonding rituals are expressions of the use of power by the military which inadvertently creates a collective at the expense of the individual (Wadham 2016). Through obedience to superiors, socialisation fosters tribalism, 'intragroup trust', and can be experienced as a symbol of exclusivity, unit cohesion, and loyalty (Martin Hummer 1989; Higate 2012). As a necessary component for capability, the elevation of the group over the individual has positive associations – many which continue post service. However, when an individual is perceived to not conform to the group (including during transitions), this subconscious socialisation process can potentially create significant problems for an individual within multiple and overlapping areas including personal, professional, health, and access to care.

Socialisation practices are dividing practices: individuals must either become divided within themselves or divided from the group (Hooyer 2012; Wadham and Morris 2019). What this means is that when individuals require assistance, both in-service and post, they are only left with a perceived choice of two negatives. It is a form of institutionalisation where individual needs come second to the common goal of the institution. Notably, once indoctrinated into the system, an individual becomes part of the system. Due to group orientation and institutionalisation, it is questionable whether an individual, within the ADF sphere of influence, has the capacity to objectively assess or critically analyse limitations within the system to which they are indoctrinated. This is significant given that power is not only centralised through an authoritarian and hierarchal structure of the ADF but also that much policy is produced through consultation with individuals orientated towards the institution. Arguably, an over reliance on institutional perspectives weakens ADF capability and creates perpetual systemic limitations; a process which significantly affects veteran outcomes and creates unnecessary and avoidable burdens on the system.

Within the context of the ADF, decreased individual agency, the chain of command, and reliance on the institution

for welfare creates a co-dependent relationship between the individual and the institution. Importantly, many individuals join the ADF with minimal or no adult experience. As a result, self sufficiency is a foreign concept. Cowen (2005) likens service within the military to a form of 'welfare for work', where individuals work for access and entitlements to public goods and care. As a result, the individual becomes fully reliant on the institution for their survival. Coupled with the elevation of the group over the individual, 'welfare for work' has real consequences for how well individuals' transition and re-orientate towards the civilian sphere.

Whilst military socialisation has been traditionally understood in terms of social cohesion through social background, current cultural changes are increasingly encouraging group cohesion through team work and professionalism (Woodward and Jenkins 2017). Personnel are accepted within groups based on their capacity to execute the role required and not identity politics. Whilst the Department of Defence and the Australian Human Rights Commission work closely concerning female participation it is completely silent on the subject of other forms of discrimination including disability. This is surprising given that individual agency which is much diminished within the ADF may result in significant human rights violations against its own members. Due to the nature of military institutionalism and group orientation, hybrid forms of socialisation, will remain. Within the contemporary setting, socialisation practices and group cohesiveness are not about identity but, rather, power and the use of power; focusing on social background and identity allows systemic issues to remain embedded. As a result, whilst *Pathways to Change* (2012) is about evolving the ADF as an institution and as a community of professionals, without an informed understanding of contemporary service, unintended consequences are already foreseeably manifesting (see ARC research).

1.4.3 Rank and Command

Rank and command are a fundamental hierarchal system of power within the ADF. Power is centralised within this structure - which overlaps with the judicial and medico complexes. It is based on an authoritarian rule and control structure with enforceable discipline. As a functional imperative of the ADF it is a cornerstone of military institutionalisation and manifests through every facet of the ADF ordering and managing personnel through diminished individual agency (Woodward 2014; Hooyer 2012). It is an avenue for significant systemic misuse due to enforceable discipline, punishment, rank association, and adherence to group orientation over the individual. A plethora of examples exist in both the media, literature, inquiries, inquests, reports and investigations pertaining to misuse of power through the ranks. Misuse of the command system has been linked to, but not limited to, sexual and physical abuse, bullying and workplace harassment, career destruction, misuse of information – including medical documentation, WHS incidents, redirecting justice, and failure to report. Notably, abuse of power within the command system creates a mistrust of command and undermines capability. Socialised to rely on command for survival, it has real consequences for the wellbeing of individuals who experience the misuse of power particularly through the loss of group identification.

The misuse of power through the chain of command is further compounded by the outdated class distinction between Commissioned Officers and Ordinary Ranks. This does not infer that all Commissioned Officers misuse power, rather, it highlights weaknesses within the system in which the misuse of power may systemically occur. Commissioned Officers are socialised and institutionalised in particular ways which manifest in class-based affiliation to tribal tendencies as well as intensified orientation to protect the institution over the individual. The socialisation process affirms an elitist identity within a naturalised perception of right to command over responsibility to lead. Within the contemporary context, this is further compounded by ADFA where many Cadets enter without adult experience and are institutionalised as elites within a structure of enforceable discipline. It not only creates a culture of privilege and rights over responsibilities but also adherence to the institution over individuals under their command.

Differences in rank within the command structure mean that individuals with the lowest rank have the least amount of agency, status, power, social and economic capital plus knowledge on how to navigate a siloed institution. In other words, the lower the rank the higher the co-dependency on the institution. Through this lens, those with the lowest rank have the highest susceptibility to misuse of power and harm. Whilst some consequences are significant in nature many are subtle. This subtlety means that an individual increasingly becomes institutionalised and perceives no other

option but to positively align with behaviour that would not be acceptable in other public, or private, Australian environments. Arguably, within the contemporary setting, it is the centralised and hierarchical complex of power which significantly effects how personnel are managed, or mismanaged, which contributes to decreased capability and poor veteran outcomes.

1.4.4 Seeking Treatment

Within the contemporary setting, the ways in which individuals must navigate systems of the military-medical complex means that individuals are trapped within two overlapping systems of power. First, the individual must overcome the fear of seeking treatment via command. Second, they must prove the injury exists through a medical diagnosis. Communicating with, and navigating, these complexes can be very difficult for personnel as they retain deference to group orientation but require assistance that elevates the individual over the institution (Wadham and Morris 2019). This does not simply affect the way that an individual perceives themselves but also how the group, and notably command, perceives the individual within a nexus of competing agendas and objectives. Notably, the fear of seeking help, and consequences for seeking treatment, is further compounded by the disclosure of personal medical information. Within the ADF health system, ADF health professionals are also institutionalised through employment with, or proximity to, the military. Through enforceable adherence to the command structure, there is an increased potential for sensitive medical information being shared at the expense of an individual's right to privacy – leading to compounding feelings of anxiety and mistrust. The capacity to trust health professionals is further diminished by the posting cycle and changeable contract arrangements within Joint Health Command. What this means is that personnel have limited ability to establish trusting relationships with those responsible for their care. Whilst the processes and policies are sound, the mismanagement of people within two overlapping systems of power often have disabling and career ending effects for serving personnel (Gallagher 2016). Individuals caught in this paradigm often feel betrayed by the ADF. The compounding feelings of betrayal, decreased health, grief, lost identity, and reverse culture shock are significant contributors to compounding health issues, veteran suicide, and, consequently, diminished life trajectories (Wadham and Morris 2019).

1.4.5 Cultural Change or Institutional Denial?

The question of military systems of power in the ADF has been the subject of no less than 60 inquiries or reports over the past 45 years. Since the late 1990s there has been a rise in organisational investigations of the military around cultural reform and the military judiciary system. The frequency of such reviews and the regular fact of ongoing incidents resulting in varying levels of public scrutiny is a testament to systemic limitations that continue to haunt the ADF. Whilst, many internal practices are unintentionally supported by the ADF through systemic limitations, when questioned, responsibility is consistently diminished, denied, or neutralised; a practise which undermines the ADF's reputation both externally and internally.

Denial within the ADF manifests in a culture of non-reporting and/or failure to manage incidents appropriately (Broderick 2013). Denial is a clear representation of institutionalism where members of the ADF, particularly command, 'protect' the institution, or tribe, at the expense of the individual. This is highlighted in the *Pathways to Change (2012, p. 23)* in which the ADF reinforces its position of self-investigation by refuting recommendations from multiple Reviews that have called on the ADF for an independent, accountable and transparent framework with view towards it its processes, systems and policies. Notably, without an independent power with authority to counterbalance the authoritarian structure and the centralised military-power complex of the ADF, the protection of the institution will always be perceived to come before the wellbeing of the people within it. Further, the perceived protection of the institution over the individual creates a climate in which personnel feel betrayed and mistrust the institution that they 'signed on the dotted line' to serve.

1.4.6 Processes, Systems, and Policies

Processes, Systems and Policies within the ADF are quite often well targeted. It is the management, or mismanagement, of ADF systems by people via the command structure which impacts negatively on individuals

within the institution (Howell 2010; Gallagher 2016; Senecal and Macdonald 2017; Molendijk, Kraner, Verweij 2015). Many problems arise when discretions are utilised within the command structure that individuals do not possess. This discretion is a consequence of a centralise power complex, institutionalism, tribalism, and the disciplinary nature of the command structure. The *Review of the Management of Incidents and Complaints in Defence* reinforces that protocols within the ADF are mostly fitting, but actions taken when people act outside these boundaries are not effective. The mismanagement of ADF protocols is a structural and a systemic limitation (Howell 2010; Gallagher 2016; Senecal and Macdonald 2017; Molendijk, Kraner, Verweij 2015). Due to the centralised power nexus, this systemic limitation affects all facets of the ADF structure including the chain of command, the Military Justice System and, Joint Health Command. This raises the question of the separation of powers and independent investigation, accountability, and transparency.

1.4.7 Inquiry, Investigation, and Review

There have been numerous inquiries dealing with various aspects of Defence's system of inquiry, investigation and review in the past. Overwhelmingly, these have been in relation to ADF systems. In terms of the Military Justice System, there are three distinct areas – military inquiries, military discipline, and administrative action. Each one has a different pathway and each one has different standards of proof. However, it is colloquially affirmed that command has preference towards the administrative pathway due to its lowered standards of proof.

Under the Military Justice System administrative and discipline pathways can be employed either independently or in parallel. In terms of the administrative, to conduct an Inquiry there is no requirement for the person conducting the inquiry to have formal training in legal matters such as legislative interpretation or the operation of law. Under the administrative pathway, there is also no obligation to conform to the requirements of the Evidence Act regarding standards of proof and categories of evidence such as Hearsay, or Secondary Hearsay Documentary Evidence. This gives the Investigations Officers, who are Commissioned Officers, wider scope to afford weight to the materials presented to either substantiate a person's complaint or the respondent's right of reply. This is the pathway that is often used to circumnavigate justice within the system.

The use of the administrative system is a form of tribalism and institutional denial where command is susceptible to protecting their own and ensuring the reputation of the institution. Whilst ADFIS and IGADF are avenues outside the direct command structure, their independence is also markedly flawed by institutionalisation, tribalism, and institutional denial. Notably, it is procedurally dangerous to call on employees of the ADF to make judgment calls in relation to internal investigative processes. It must be questioned as to whether the investigators, be it chain of command or officers from ADFIS or IGDAF, have the necessary experience and more importantly independence to be making "recommendations" in relation to allegations regarding potential criminal or common law investigations involving itself - the ADF. As a result, subjective "recommendations" or outcomes are administered allowing the ADF to continuously shift liability from internal systemic failures and limitations onto the individual. This may compromise a persons' entitlement to future care and any potential criminal or common law complaint.

In sum, independence, accountability, and transparency, particularly within institutions that limit individual agency, is vital to ensure that fair procedures and processors are respected for individuals operating within such systems. If incidents occur in connection with the ADF workplace, personnel should be entitled to a scheme and investigative process independent of the ADF that allows them to pursue their common law rights and to receive due compensation, based on an appropriate scheme, that acknowledges the effects of working within an institution with limited personal agency.

1.4.8 Military Abuse

Abuse in the military is an expression of the institutional contexts and functional imperatives of the ADF (Wadham 2014; McKenzie 2008). It is integral to the socialisation processes of the military. Abuse includes but is not limited to physical and sexual assault, bullying and harassment, career destruction, deprivation of liberties and privacy

breaches, abuse of systems and power, and abuse of authority. It can be extreme, or it can be subtle. It is not about gender or identity but about power. As Wadham (2014) highlights, the ways that hierarchal structures of power are articulated, interpreted, responded to and accounted for are integral to understanding abuse within the military. It is constitutive of military culture, rather than pathological or abnormal. Whilst the deprivation of liberties is a required functional imperative, this requirement intentionally/unintentionally supports a culture that has human consequence. This system is internalised by the military subject, too often sanctioned/supported by command, and concealed by silence (Wadham 2013).

Individuals who have been mistreated within the military have significant mental health problems including self-harm and/or suicide (McKenzie 2008). Studies (Yaegeer et al 2006; Cornish 2017) suggest that personnel who have been subjected to mistreatment have a higher prevalence of mental health conditions, particularly anxiety disorders, than personnel who have deployed; these findings correlate with finds from the 2018 *Mental Health and Wellbeing Transition Study*. This is particularly the case for female veterans with research suggesting that more female veterans suffer from PTSD from military sexual assault than from deployment (Mckenzie 2008; Yaegeer et al 2006; Cornish 2017). Further, the Australian investigation into youth suicide and mental health highlights that the significant factor contributing to poor health outcomes for Australian youth is public humiliation – something which is systemic within the military system. Abuse in the military is not only constitutive of identifiable experiences. Arguably, it is the everyday effects of diminished individual agency within an institutional setting which silently affects an individual's psyche (Howell 2010; Gallagher 2016; Senecal and Macdonald 2017; Molendijk, Kraner, Verweij 2015, Wadham and Morris 2019). In other words, it is the day to day effects of military socialisation and systems of power, coupled with unrelenting training regimes and no foreseeable end in sight, that breaks the psyche and affects a person more than any singular trauma or injury (Morris 2019). This is increasingly becoming a benchmark for understanding the effects of contemporary service.

1.5 Beyond the Institution

The ADF not only shapes the daily lives and lived experiences of those working within the institution but also with those within a sphere of influence to the organisation. Mostly, this is not an intentional exercise but a subconscious socialisation process which occurs due to proximity to the organisation. In this way military configurations influence not only people but also other organisations and institutions including ADF veterans and their families, from the Department of Defence to the Department of Veteran Affairs, from Ex-Service Organisations to the broader Veterans Sector. Arguably, the totality of the socialisation process of military service and the effects of such service creates a requirement for the veteran community to be recognised as its own cultural group within society.

With view to the above, any reforms should not be limited to the ADF (or DVA) but also needs to encompass how contemporary service interfaces with transitions, families, and the broader Veteran Sector. Currently there is a lack of knowledge and understanding of what contemporary service entails and how this service differs to other service eras. Too often within the wider community the narrative of 'return from war' is utilised for political leverage and financial gain whilst contemporary veteran outcomes remain poor. Whilst a 'return from war' narrative does hold currency for contemporary combat veterans, its full relevance is situated within older service eras and not the current era. Due to this confusion, much policy, governance, and systems of care for the contemporary cohort are poorly targeted. Notably, targeting needs and policies within the community is an arduous endeavour given that the demographics of the veteran community is inclusive of all service eras and not just the contemporary era. This means that what may be required for one cohort may not be well targeted, or even be relevant, for another. Whilst this submission predominately focuses on contemporary service, it is important to acknowledge that any reforms should be sensitive towards, and respond to, the diversity of needs within differing service eras. Responding to differences of need is a multifaceted and complex task – one that the DVA has continuously had to try and balance. Policy and reforms which understand how contemporary service shapes experiences and outcomes within the broader veteran community will not only improve veteran and family outcomes post-service but also strengthen contemporary ADF capability and retention of personnel in-service.

1.5.1 Transition

Whilst it is well recognised that the military changes spaces, places and people, these changes also continue to have an important bearing on post-service life (Woodward and Jenkins 2011; Bulmer and Eichler 2017). Within the contemporary era, post-service experiences can be very different for men and women, are shaped by individual agency, military identity, and ideas around militarisation and civil/military relationships (Wooodward and Duncanson 2017). However, the transfer between military/civilian spheres is not linear. Rather, the transfer is spherical between relatively porous communities with different but overlapping agendas, priorities, culture and understandings. In other words, transitioning cannot be reduced to a binary of either military/civilian or in-service/post-service. Transitioning is about continual change within shifting but overlapping environs and spaces. A key concept in understanding the lives of veterans, as ex-military subjects, is that they are neither military or civilian but occupy a between-ness, or, liminal space (Herman and Yarwood 2014). This space often affects how veterans view themselves and interact with the wider world.

Transitioning from the military tends to focus on the back end of military service. However, veteran transition has more to do with contemporary military service, not just leaving the military (Wadham and Morris 2019). Transitioning is a cultural practice and a social phenomenon. It is much more than simply a psychological state or process. It cannot be fully quantified, and nor should it be medicalised or pathologised - to do so situates the veteran, yet again, as something to be fixed and controlled. Transitioning is about how the state, the military and civil society conceives of veterans, how veterans see themselves in that triad of forces, and how they learn to navigate these new roles and obligations (Wadham and Morris 2019).

There are positive and negative transition outcomes for service personnel when moving into civilian life. Issues associated with transitions include health problems, financial worries, social difficulties, employment and education barriers, abuse of substance and alcohol, relationships problems and divorce (Black and Papile 2010). Many of these issues derive from the everyday consequences of contemporary military service. However, it is during the process of transition, and moving between two different environments, that the consequences pertaining to diminished individual agency, socialisation, and institutional denial become apparent; the differences between the functional and societal, the military and civilian landscapes. Whilst some consequences are apparent, many are subtle and continue to shape life trajectories well after service has ended.

During transition, service personnel must navigate a complex cultural transition when moving between overlapping spaces. Bergman, Burdett and Greenberg (2014) point toward this tension by employing a model of 'reverse culture shock' to describe the unexpected difficulties some personnel experience. Culture shock is a result of being socialised into military culture and then transitioning back into civil society. Both the individual's frame of reference and the civilian culture itself may have changed, leading to difficulties in navigating a now unfamiliar environment. The shock is further enhanced by moving from a rules-based group orientated institution, into a value laden individualistic society, and by the plurality of services across multiple agencies. Such differences can be dis-orientating, and re-negotiation challenging, particularly within a climate where there are less commonalities between the military/civilian environs for individuals to utilise as an anchor point for reference. Whilst there is no singular framework which can guarantee transition outcomes, what is apparent is that the more 'tools', capital, and anchors that an individual has (social, relational, financial, educational, professional), the more likely a successful transition. Notably, integration is not lineal, and nor can it be neatly categorised. Integration is a process that requires time to navigate the cultural gap and changes in norms and roles successfully. Arguably, for contemporary veterans, time and a fixed anchor are two key elements to successfully bridging the divide between the two spaces.

For those medically discharging or requiring care from DVA, a veteran's transition from the ADF may also include navigating multiple agencies and networks of power. Networks of power within this complex include the ADF, DVA, and bio-medicine. Communicating with, and navigating, these entities can be extremely difficult for the veteran

particularly as they retain a deference to group orientation and socialisation processes which may make them hyper-sensitive and suspicious towards the military complex. There are two principal ways that difficulties of navigating the complex arise (Wadham and Morris 2019). First, how both the ADF and DVA construct the injured individual - as a liability. Second, how management of care is obstructed, and in instances denied, through the complexities of traversing multiple agencies on which the individual is dependent. A lack of awareness and control over processes leaves veterans vulnerable to competing systems of power required for treatment and assistance. For many, this process becomes a stark reminder of the misuse of power and systemic limitations experienced within the ADF; a betrayal of the care they were promised to receive.

To create a system fit for purpose now and into the future, it is important to understand how the effects of contemporary service and the cultural military/civilian divide influence transition trajectories and outcomes. As a form of 'reverse culture shock', time, continuity of care, and a stable reference point are key elements towards successful transitions. Whilst there is real benefit in considering the veteran community as a stand-alone cultural identity, there could also be lessons to learn from other sub-groups within society. To assist in the formation of well targeted transitions policies for contemporary veterans and their families, conversations with researchers, government agencies, and frontline providers within the spheres of high-performance sport, immigration, institutionalisation and prisoner reintegration may be of some benefit.

1.5.2 The Veteran Sector

Beyond the institutional framework of the military lies the veteran sector which has evolved and grown significantly within the contemporary era and with the medicalisation of care. The way that relations of care are now embedded in broader politics and market forces creates a sector in which organisations jostle for authority and government contracts (Alcock 2012). As a sector which has not been required to comply to the same standards of independence, transparency, accountability or budget constraints as other public funded sectors, a focus on political power and financial gain as opposed to veteran care becomes systemic. This puts the veteran sector, and therefore the community, at a marked disadvantage to other sectors who rely on professionalism, research, independence, transparency, and accountability to build trusting relationships and drive better outcomes for clients. Political lobbying has been brought in house by DVA through the ongoing employment of individuals who hold board positions within powerful and influential lobby groups. This has led to the establishment of organised power blocs within a government department with the intent to influence policy. Whether this is a real, or perceived, conflict of interest it elevates, through proximity and position, the politics of one faction over the rest of the community. Significantly, the process is based on biased opinion as opposed to an objective systematic process of research and inquiry to inform well targeted policy and legislation. This is of concern particularly as it has been endorsed and funded by both the DVA and the associated Minister. Further, the plurality of services and agencies which characterises the sector is argued in neoliberal parlance to create a more changeable and contingent environment of care for individuals to negotiate (Wadham and Morris 2019). This is significant because many contemporary veterans have not had a continuity care or the capacity to build trusting relationships with providers during service. Arguably, confusion within the sector is increased, and sustained, by a lack of awareness relating to not only contemporary service but also an awareness of the needs for many within the broader veteran community.

Medical and institutional narratives are often at odds with the lived experiences of not only contemporary veterans but, in some instances, the broader veteran community (Molendijk, Kraner, Verweij 2015). Often contemporary veterans must attend on a provider who is said to understand the DVA 'system' in order to navigate the medico-military complex. This perpetuates a cycle in which both veterans and providers become focused more on how to 'prove' a condition than receive necessary treatment and care. It is colloquially understood that psychiatrists often over diagnose trauma in relation to contemporary operational deployment. Majority of contemporary deployed personnel do not witness atrocities first hand or are deployed into combat, or in direct support of, combat positions. Yet, trauma from operational duty is the narrative continuously affirmed inside and outside the ADF, throughout the veteran sector, and disseminated through society. This does not suggest that trauma does not exist or that it is not related to service, nor does it suggest that some trauma does not arise from operational deployment, what it suggests

is that there is potentially a lack of understanding surrounding the origins of trauma when considering contemporary service. This lack of understanding perpetuates a cycle in which veterans and providers alike must align with the narrative of 'returning from war' to receive the required liability to access treatment and care. This perpetuates a narrative which may, in fact, be the largest barrier to many contemporary veterans receiving the care they require.

Within the veteran sector, many organisations are dependent on government contracts and continuous funding arrangements. This undermines their position as independent actors (Alcock 2012). Academic/commercial operations have become intrinsically aligned with both DVA and the ADF. Not including ongoing income derived from both state agencies, there is a real or perceived bias and conflict of interests with the same people (including ADF and DVA employees) filling multiple positions on board memberships and councils across the sector and within government departments. Further, both DVA and ADF contract private organisations to undertake research to ensure confidentiality of results, this situates them as appendices to the state apparatus as they become reliant on the government for income (Herman and Yarwood, 2015; Defourney and Nyssens 2010; Phillips and Hebb 2010; Smith, 2010). Through centralising power within a controllable environment, knowledge produced by such organisations becomes aligned with government imperatives that systemically confound care and governance while veteran outcomes remain poor. Arguably, the confusion of what contemporary service entails means that some research areas may be being over researched whilst other areas significantly neglected. Notably, many memorandums of understanding are being struck between Australian tertiary institutes and the DDVA HREC which requires all research to be centrally controlled and subjected to a vetting and censorship process under the guise of ethics before public release. This creates a real or perceived control of knowledge by both the DoD (ADF) and the DVA. Controlling the sector through financial dependence and access to research is a clear representation of the military's sphere of influence and systemic limitations. It undermines the ability for transparent and independent research, it undermines the accountability of both the DVA and ADF to the public, and it undermines well formulated policy for the betterment of the veteran community. Therefore, reforms should consider ways to build trusting relationships and ensure transparency, accountability, independent research, and best practice within the veteran sector.

1.5.2 Ex Service Organisations

At the community level of the veteran sector is a network of Ex Service Organisations (ESOs). These organisations range from local grassroots organisations through to national corporatist structures; an assemblage of charities, social enterprises, community groups, non-governmental organisations and co-operatives. While some focus on a single issue, others are broader in scope connecting to a particular time frame, regiment or service. Over-time, this had led to a highly politicised unregulated sector characterised by confusion, overcrowding, duplication of services, and a lack of cohesion and direction. The lack of direction and confusion within the space derives from multiple needs arising from diverse demographics spanning differing eras of service. A lack of regulation and knowledge within the space undermines required care to vulnerable populations who do not possess the political power, or proximity, to influence well targeted policy or legislation. This is particularly the case for contemporary veterans and their families as lived experiences become silenced through historical narratives about 'returning from war' as opposed to the effects of current military service. This also has significant flow on effects for transitioning personnel who are often overwhelmed and confused by the space. Following a Ministerial Statement release urging the sector to unify and collaborate (Ministerial Statement, 2017), an array of divergent configurations from differing factions within the community has emerged – the most successful of which is the Alliance of Defence Service Organisations (ADSO). While ADSO commands a strategic position and retains a focus on the overall welfare of the community, the Alliance notes that it is still modernising services to engage constructively with the contemporary community. Notably, asking the sector to speak 'with one voice' through a configuration of lobby groups is counterintuitive to understanding the needs of the community, particularly the vulnerable who are often silenced by the power of politics. Arguably, what is needed is co-ordination and direction by a professional independent body, not unification via the community. The lack of direction and cohesion which haunts the sector can be evidenced in tensions between and within organisations over competition for resources and authority.

The Australian ESO space is characterised as intensely competitive and considerably tribal (Wadham and Morris 2019). ESOs have traditionally drawn on a strong sense of mateship – of those who have served. Much criticism has been drawn towards the ESO space from younger veterans as organisations express the military disposition in terms of hierarchical structure, rank association, reliance on rules and regulations, and tribalism. Dubbed as 'mess committees on steroids' some organisations are viewed with suspicion due to a prevalence of ex-officers, infighting and a growing belief that some ESOs are more interested in maintaining relevance and position as opposed to the welfare of veterans. Whether the criticism is justified, it highlights a disconnect between the veteran sector and the needs of contemporary and currently transitioning personnel. Not only is the lack of professionalisation within the ESO space impacting the capacity to connect with society and contemporary veterans alike, it creates a space where power and position supersedes the needs of vulnerable populations. Hence, reform should consider ways to modernise the ESO space through co-ordination and direction via the production of research within the veteran sector.

1.5.3 Families

Military and veteran families are also influenced by the military. Whilst families play a central role in supporting personnel and the military institution, too often their supportive role is normalised and receives little recognition or assistance (Rouleau et al 2013). During military service, the provision of housing, welfare, employment services, and counselling the family unit means that the family may also become dependent on the military. As the military significantly influences every domain, families often encounter emotional, financial, relational and physical stresses and/or opportunities including, but not limited to, geographic relocations, educational and employment barriers, risks associated with combat exposure, disability, and familial separation. These stressors not only significantly affect child development and functioning but may also undermine the family's ability to respond to everyday stress adequately (Borah and Fina 2017; Gray 2017). Military families are expected to cope with hardships of military life with resilience, stoicism and self-reliance, and avoid asking for help as much as possible (Harrison ad Laliberte 1994; Horn 2010; Gray 2017). Whilst this idealisation does not reflect the characteristics of all military families, it does describe a set of norms, or parameters, to which many find themselves held to account (Ware 2012, p. 207). Based on this understanding, it is questionable as to whether the results from the 2018 *Mental Health and Wellbeing Transition Study*, that suggest that majority of families are doing well, is a reliable and accurate source of information. The validity of these results is further undermined by a lack of research relating to both service and ex-service families. This makes it difficult to properly assess the effects of service on families – irrespective of era served. Whilst different service eras impact families differently, families are situated within the broader context of society. Therefore, outcomes for family units, including the veteran, may cross generations and are often influenced by both broader societal change and service requirements alike.

Within the current Australian context, there are three key positions relating to the vulnerability of military families. The disability family, the separated family, and the family of the deceased. Each are significantly impacted and shaped by the military. Issues that vulnerable families face include, but are not limited to, disability care, health issues, financial issues, blended families, family breakdown and court issues, intergenerational sexual trauma, intergenerational poverty, intimate partner violence, intergenerational trauma, intergenerational health issues, secondary trauma, grief, and death. These categories are acknowledged, resourced, and legislated differently by the ADF and DVA, and the Veteran Sector - even though all are negatively impacted by military service. Relationship to the veteran, service era, service rendered, association to an ESO, and liability can also significantly alter the experiences and assistance that families receive. Across the spectrum, children are singularly the most vulnerable population.

The disability family is recognised through 'caring' for a loved one. Historically, individuals requiring care were cared for by the state within institutions – this was particularly the case for returned veterans from WW1 and WW2. However, caring for disabled individuals is now predominantly undertaken at home by family members. This increases the physical, psychological, and financial burdens for these households. In terms of the Australian veteran

community, this role is predominately undertaken by the spouse but sometimes falls to either children or parents of the veteran. Many families do not have an active choice about providing care as various social realities align that construct their life world including social and economic realities, as well as policy and service paradigms (Armstrong and Armstrong 2002). Whilst positive outcomes of care-giving, such as enhanced relationships between the care-giver and care-receiver have been explored (see Rutman 1996), negative outcomes are also present. Negative repercussions relate to the capacity for financial security, employment status and earnings, physical health and psychological well-being, and everyday life opportunities (Wiles and Rosenburg 2003; Yantzi et al 2007; Lee and Porteous 2002; Morris 2004; Wakabayshi and Donato 2005). There is often much confusion between the differences of 'caring for' and 'caring about' with minimal policy and support from the DVA for disability families. For clarity, whilst 'caring for' relates to disability service and care, 'caring about' pertains to care associated with familial bonds. This group carries a significant physical and psychological burden which is often compounded by other familial duties. The vulnerability of children within these households is extreme particularly when there are high levels of disability within the home.

Separated families are also significantly vulnerable. Historically, divorce and relationship breakdown was not a common occurrence. In society today, it has become a norm. For military personnel, divorce and separation rates are significantly higher than the broader population (Marshall, Panuzio, and Taft 2005; Rents et al 2006). Many military families predominately separate due to the consequences of military service including but not limited to service conditions such as posting cycles, infidelity, poor health, and intimate partner violence (IPV). The prevalence of IPV within military settings is approximately three times higher than rates found in the general population (Marshall, Panuzio, and Taft 2005; Rents et al 2006). Intimate partner violence in the Anglophone military institutions is understood to be a consequence of the ways in which individuals are shaped/influenced/affected by military service (Gray 2017). IPV does not only effect women. Victimisation is experienced by both males and females, veterans and spouses, with female spouses just as likely to perpetrate IPV as male veterans (Gray 2017). Further, children and young people are particularly vulnerable/sensitive to abuse in families. This is due to their dependence on family members, and the way in which society views children (Borah and Fina 2017).

Familial separation may increase health and welfare issues for the veteran, the spouse, and children. Once separated, family members receive little recognition or assistance from either the ADF, the DVA, or the broader veteran community. This is of consequence as many have become co-dependent on the system, acted as care-providers, or suffered trauma, and are still in the process of raising children; children that have witnessed abuse, separation, and disability within the home. Due to a lack of recognition and appropriate policy and supports by both government agencies and the broader veteran sector, separated families, including the veteran, are arguably the most vulnerable of the three groups. With compounding and complex issues which are the least understood or acknowledged within the sector, they also carry the largest financial burden and vulnerability to poverty.

Vulnerability is also high in families where the consequences of service result in death. Vulnerability within this group is variable and is often contingent on the era and the cause of death, the familial relationship to the deceased, and access, via membership, to resources. Historically, death of a family member has been associated with the war widow and the government's requirement to care for families who had lost the sole breadwinner during war. Today, irrespective of era, war widows are often well cared for by the both the government and the veteran sector and receive due compensation for their spouse's death. Majority of contemporary widows are service widows with deaths being related to service related injuries and diseases. Due to the political leverage of the historical narrative which singularly views military death through a lens of 'sacrifice of war', many contemporary widows struggle to access timely compensation and support for their spouse's death. Whilst the historical narrative is undoubtedly a lived reality for some widows, it confounds assistance for many contemporary widows. Struggles in receiving timely compensation and support has significant flow on effects for these vulnerable households particularly when children are also involved. Further, there is limited support and services for other family members during times of grief. This is especially the case for parents who are often still the base family unit for single veterans.

In sum, reforms should support vulnerable families by considering how military service impacts families and how the needs of families have changed within the broader context of contemporary society and service.

1.6 Conclusion

The purpose of this section was to assist the Productivity Commission by offering research within areas that have not been actively explored, but which are vital components in understanding the nature of contemporary service. Currently there are numerous systemic limitations within the ADF. Within the contemporary setting, systemic limitations are significant contributors to poor veteran, and family, outcomes - yet this knowledge is continuous hidden under narratives about ‘returning from war’.

Limitations are systemic because, within the ADF individuals have limited agency and must adhere to a strict disciplinary command structure; individuals cannot exercise rights that they do not possess. It is systemic because those that do have power often exercise rights and discretions that they do not possess. It is systemic because it is an institution that continually investigates itself. It is systemic because individuals and families are dependent on the system. It is systemic because there is no transparency and accountability. It is systemic because internal investigators and reviewers are also institutionalised. It is systemic because institutionalism is a requirement for capability. It is systemic because the ADF is a regimentally stratified tribalistic institution. It continues to be systemic because there is no incentive or consequence for failure to comply to the systems that govern. It continues to be systemic because there is no separation of power and no independent authority to balance the authoritarian power of the institution. More often than not ‘mission command’ is used as a through away line when, in fact, there is actually no instrument to justify the discretion.

Any new scheme or recommendations need to strike the right balance between functional and societal imperatives, between necessary capabilities whilst ensuring the welfare of individuals within the institution. Reform should not be limited to the ADF (or DVA) but also encompass how systemic limitations and contemporary service interfaces with transitions, families, and the broader Veteran Sector. Reform which ensures transparency, accountability and the welfare of personnel at all stages of a member’s military engagement and beyond will not only improve veteran and family outcomes post-service but also strengthen contemporary ADF capability and retention of personnel in-service.

Section two: Responses to findings, recommendations, and information requests

Chapter Four

Draft Recommendation 4.1: Objective and principles

Supported.

Chapter Five

Draft Finding 5.1: Work Health and Safety Act

Agreed.

Draft Finding 5.2: Under reporting

Agreed.

Information Request 5.1: Under reporting

The under reporting of WHS incidents is impart due to the complexity of the system to navigate which impacts time allocation for members to report incidents.

Reporting rates can be improved by making it more user friendly and by further educating members, particularly lower ranks, on the WHS and incident reporting system. Handbooks and cheat sheets would help to navigate the system.

Draft Recommendation 5.1: Augmenting systems

Supported. Trends could be tracked to improve future outcomes.

Draft Recommendation 5.2: Injury Prevention Programs

Supported. The reduction of injury will also require a culture to support personnel.

Draft Recommendation 5.3: Published estimates

Supported. As a public institution, transparency is important.

Chapter Six

Draft finding 6.1: Rehabilitation between ADF and DVA

Agreed. DVA relies on ADF rehabilitation.

Draft Recommendation 6.1: Joint Health Command Reporting

Supported.

Information Request 6.1

Note on: Rehabilitation service and effectiveness and access is better in service than out

It is a current practice within the ADF that when members tell their rehabilitation provider that they 'just want a medical discharge' this is what occurs. Therefore, the effectiveness of rehabilitation in DVA will be lower than the ADF as many members have no desire to rehabilitate.

The misuse of medical and administrative discharge via command also impacts rehabilitation effectiveness.

It is commonly understood that outcomes are lower for return to work the more time an individual is away from work. As the time within the ADF is approximately one year before discharge, this has a flow on effect for the effectiveness of DVA rehabilitation.

Veterans also suffer from 'appointment exhaustion' and grow tired of being a 'patient'. Multiple rehabilitation programs add to this 'exhaustion'.

It is also common practice for Command to push members down the medical discharge path instead of offering proper rehabilitation as a means to stigmatise. Additionally, personnel are often discriminated against when they do enter a rehabilitation plan within their own work group.

Notably, some members choose to privately receive care outside of the ADF health system. Members choose this path to decrease the chances of stigma which is inherently built into the ADF system and to optimise their health outcomes. Health professionals outside the ADF system are quite critical of the standard of care and rehabilitation that many members receive within the ADF including out of date practices which prolong rehabilitation and injury leading to poorer veteran outcomes. This raises a question pertaining to whether current medical arrangements are meeting the needs of individuals.

Draft Recommendation 6.3: Improved rehabilitation arrangements

Qualified support.

Receiving coordinated care in-service is easier than post service. Within the ADF, health care is centrally located and members are expected to adhere to process and continue treatments – members have little agency or control over their own health. Whilst that makes it easier for personnel in-service, it makes it very difficult post service. Post service responsibility for health returns to the veteran who usually has had very little experience in co-ordinating their own care. Further, as they have been in the ADF health system many post service do not have relationships with external health providers. Building a trusted relationship with a health provider takes time. This impacts on post service levels and continuity of care.

I agree that Defence and DVA need to engage with more rehabilitation providers, and to monitor and report outcomes. I agree that changes are also required to the arrangement for providing and coordinating rehabilitation immediately prior to, and immediately post, discharge. I would advise that they should be coordinated by Joint Transition Command. Refer to Section three of this submission.

Information Request 6.2: Consumer Directed Care

Please refer to Section two of this submission

Chapter Seven

Draft Finding 1: Transition climate

Agreed.

Draft Recommendations 7.1, 7.2: Transition

Qualified support.

I agree that Defence should take responsibility for transitions and that transition services need to be consolidated in one area. I agree with the functions outlined for transitions. I strongly advise against a Joint Transition Command.

A Command structure within the ADF is counterintuitive to assisting personnel transitioning smoothly. What is being asked is for institutionalised people to tell other institutionalised people how not to be institutionalised when they leave the institution. Refer to Section three of this submission for an alternative approach.

Information Request 7.1:

Post military transition services should be for 5 years post discharge. Five year allows individuals and their families time to re-adjust and re-orientate in a supportive and reflexive way; time, continuity of care, and a stable anchor are key to successful transitions (see Section one and three). This does not mean that services are active, just that there is an 'opt in' option for up to five years post service. Over this period, members could be situated in an 'inactive reserve' pool which would also give them options to re-enter the ADF if appropriate.

The timeframe in Canada for transitions post- discharge is five years.

Draft Recommendation 7.3: Education Allowance

Supported. Whilst it is optimal for the ADF to support individuals' in-service, I doubt this will occur.

Commissioned Officers have access to a very high level of education in-service and given time to study. Ordinary Ranks do not.

Information Request 7.2: Education Allowance

I strongly support a veterans' education allowance. Education empowers individuals and assists in preventative care.

Veteran Education Allowance should be paid at the same rate as the Veteran's payment and should be administered as a scholarship

Eligibility should be for initial ROSO or by applying for special circumstances (with a minimum of two years service)

Other conditions to consider are:

- 'opt in' education/vocation package to be started within 5 years post discharge
- active Reserve member whilst studying (part of transition)
- capped at an under graduate degree (or graduate certificate if they already have an under graduate degree)
- up to one under graduate degree only (if an individual already has an undergraduate degree they cannot access the payment)
- allowance is conditional on passing each semester (or supported reasons)

Information Request 7.3: Transition needs for Reservists

Very little is known about Reservists in Australia. Preliminary research suggests that Reservists have much more autonomy, resilience, and are more self-reliant. Reservists, however, also have a strong sense of duty and identify strongly with the ADF.

Chapter 8

Draft Recommendation 8.1: Initial liability

Supported

Information Request 8.1: Standards of Proof:

Going forward (not VEA), all standards of proof should be based on a 'balance of probabilities'.

Within the contemporary era, conflict zones have become rationalised, professionalised and privatised (see Section one). A 'reasonable hypothesis' is an out of date standard with current electronic systems and information available to make an informed decision. Further, the hypothesis has obscured the source of injuries for contemporary veterans. For example, if a veteran has operational service, many advocates claim conditions under operational service as opposed to where the injury/disease originated from. This confounds care which contributes to poor veteran outcomes and financial burden.

The balance of probabilities is also the standard used in civil court and aligns with the legal framework in Australia.

Draft Recommendation 9.1: DVA Reporting

Supported

Draft Finding 9.1:

Supported

Draft Recommendation 9.2: DVA Training

Supported. All personnel working with veterans should have to undertake this training. Particularly those undertaking peer to peer support; it should be a requirement for veterans helping veterans to undertake the training too.

Draft Finding 9.5: DVA

Agreed.

Draft Finding 9.6: ESOs

Agreed. Refer to Section two regarding co-ordination. ESOs can also create power blocks limiting DVA's understanding or, and engagement with, important issues. Proximity seems to be the preference of setting agendas.

Members of ESOs are also contracted by DVA as consultants. This raises a question of bias, and again, limits understanding of issues impacting the community.

How DVA administers grants to the ESO sector is questionable. Grants should be competitive and pass the same regulations for grants of other not-for-profit organisations within Australia.

Chapter 10

Draft Finding 10.2: Feedback from Review

Agreed.

Draft Recommendation 10.1: Reporting of review outcomes

Supported

Draft Recommendation 10.2: Review of decisions

Supported

Draft Recommendations 10.3, 10.4: VRB

Supported

Information Request 10.1: Review

Education as part of a rehabilitation program under DVA framework. Currently, if it is decided that an individual does not meet DVA requirements it is not reviewable. Given the benefits of education for rehabilitation it should be reviewed.

Defence Home Owners Scheme should be reviewed and reviewable. Currently members have two years to use the scheme post service. The majority of personnel are not in a position to utilise their entitlement within two years as many realities align including, but not limited to, health, finances, and employment which makes it impossible. Arguably, some will not be in a place to access the entitlement for many years. Therefore, this entitlement advantages the already advantaged and further disadvantages the vulnerable.

Chapter 11

Draft Recommendation 11.1: Veteran Policy Group; 11.2 VCS

Qualified support. This is only achievable with appropriate systems in place to protect veterans from further harm. Refer to Sections 1 and 2 of this submission.

Draft Recommendation 11.3: Veteran Advisory Council

Qualified support. This is only achievable with appropriate systems in place to protect veterans from further harm. Refer to Sections 1 and 2 of this submission. Strongly support professionals sitting on the council.

Draft Recommendation 11.4: War Memorial

Supported

Draft Recommendation 11.5: Fully-funded compensation system

Supported

Information Request 11.1: Funding arrangements

Existing liabilities from the DRCA and MRCA should be included. This will act a strong incentive for the ADF. MRCA and DRCA are compatible with the model and are part of the contemporary service cohort. VEA should be excluded and existing entitlements protected for aging veterans.

Chapter 12

Draft Recommendation 12.1: Harmonising benefits

Supported, including the recommendation not to reassess PI for DRCA clients.

Draft Finding 12.1: Offsetting

Agreed.

Draft Recommendation 12.2: CSC

Supported.

Chapter 13

Draft Recommendation 13.1: MRCA PI

Supported. It creates inequality in the system.

Information Request 13.1: PI Level

The new PI level should stay at the peacetime MRCA rate. The peacetime rate is already higher than other comparable PI rates for workers compensation. Therefore, it still recognises the uniqueness of Service. It is comparable because military personnel are already compensated for operational service and conflict zones are now privatised, rationalised, and privatised. An injury is an injury.

Instead preventative care measures to support well-being and self sufficiency could be utilised. For example, the veteran education scheme.

Draft Recommendations 13.3: PI Compensation

Supported

Draft Recommendation 13.2: Additional NEL for children.

Partly supported.

This payment is well targeted for vulnerable families. It is a payment for high disability and increased vulnerability for children in homes that have been significantly impacted by Service. Many intergenerational problems arise from these environments. Such households have complex needs and the payment assists in stablising and normalising what is often a chaotic environment. However, an argument could be made for reducing the payment in the MRCA and future legislation per child or/and capping the total amount payable.

Information Request 13.2: Remuneration loading and compulsory superannuation

I agree that superannuation is required for retirement. If payments stop with no superannuation, it would make veterans highly vulnerable.

Draft Recommendation 13.5: Lifestyle ratings

Supported

Draft Recommendation 13.6, 13.7: SRDP

Supported

Draft Finding 13.3: Rate of special rate pension

Agreed.

Draft Recommendation 13.8: Dependant payments

Supported. The two payments should be combined.

Chapter 14

Draft Recommendation 14.1: DFISA

Supported

Draft Recommendation 14.2: Education Payments

Not supported.

The education payment for older children is well targeted for vulnerable families. It should not be administered or have the same income and asset tests applied as Centrelink. This payment is not a payment for low income, it is a payment for high disability and increased vulnerability for children in homes that have been significantly impacted by Service. Many intergenerational problems arise from these environments. Such households have complex needs and the payment assists in stablising and normalising what is often a chaotic environment.

Draft Recommendation 14.3, 14.4: Supplements and allowances

Supported.

Draft Recommendation 14.5: VEA Attendant allowances

Supported.

Draft Recommendation 14.6: Motor vehicle assistance

Supported.

Chapter 15

Draft Finding 15.1: Treatment Cards

Agreed.

Draft Recommendation 15.1: Gold Card

Partly Supported. VEA arrangements, including partner entitlements, or future entitlements, should be protected for the gold card.

Information Request 15.1: Gold Card

I support a card system for non-liability, family, and liability.

Non-liability card: Whilst I support this measure, it has the capacity to be over used. I would cap the amount of sessions per year to 12 (they are also entitled to sessions under Medicare) unless a treatment plan was submitted.

Family card: Whilst the Commission has suggested that Open Arms is the appropriate service for families in terms of mental health, I strongly disagree. As the Commission has highlighted, any new scheme needs to be 'fit for purpose' and individuals should receive 'best practice' care - this should extend to families. Open Arms has limited understanding and engagement with issues that families face including intergenerational sexual trauma, intergenerational poverty, IPV, intergenerational trauma, secondary trauma, blended families, family breakdown, family court issues. These issues require specialist treatment. Why should vulnerable family members be forced to go to Open Arms when all veterans have a non-liability card to see any practitioner – this does not make sense. Plus, a family card would cover children who are the most vulnerable cohort within the veteran community. It is essential that vulnerable families feel confident and trust their health professionals for maximising care.

This does not mean that all families require a card. Vulnerable families (see Section one) with higher risks require professional mental health care. A card should be accessible to war widows/widowers and their families, families with a high level of disability within the home, carers of veterans, victims of IPV, families form service related death, and divorced families with children for mental health services only. Other families could be sent to Open Arms for assistance.

Liability card: Treatment for all service related conditions.

Service pension and gold cards at 70

Given the contemporary service environment and superannuation contributions, the Service pension may be an out-dated pension. What may be required is a high disability, low income pension for vulnerable households. However, VEA arrangements should stay the same.

If a Gold Card is going to be issued at age 70, recipients should include:

- those with operational combat service only (or those in direct support of combat) - this acknowledges individuals who are asked to transgress the sanctity of life as part of their everyday duties. It gives properly targeted recognition and gratitude within the contemporary context which is in line with the original intention behind the Gold Card
- individuals with 80% WPI or more
- dependents who have been ‘carers’ (must be in receipt of HSS carer allowance etc) – caring takes a significant toll on both the physical and psychological health of carers (carers should not have to wait to become widows)
- war widows/widowers

Draft Recommendation 15.3: Mental Health Strategy

Doubted. To have a clear strategy DVA needs to have a clear understanding of the issues. Recent research on Mental Health has not produced reliable or independent data. This is of concern given the amount of money spent on recent projects.

Draft Recommendation 15.4: Open Arms

Supported.

Open Arms should move towards providing education and training as opposed to providing care. Open Arms could coordinate mental health services within the sector for both providers and clients in and post Service. Arguably, they should be administrating some of the frameworks that they are paying Phoenix to provide.

Information Request 15.2: Co-payments

I do not support co-payments for treatment.

A higher rate for fee setting arrangements should be applied for liability accepted treatments. A lower rate should be applied for gold card recipients and non-liability health care.

Information Request: Private Health Insurance

Not supported.

Chapter 16

Draft Finding 16.1: Research Data

Agreed.

Draft Recommendation 16.1: Performance Frameworks

Supported

Draft Recommendation 16.2: High Quality Trials

Supported

Draft Recommendation 16.3: Research Priorities

Supported. There is a requirement for DVA to ensure independent and transparent research. Research should not just be health related but encompass a social perspective as well. This will give DVA a more holistic understanding of the needs within the veteran community. DVA should also ensure that appropriate methods of recruitment are applied to research that they are funding. Inappropriate methods can result in false findings.

Chapter 17

Draft Recommendation 17.1: Two schemes by 2025

Supported.

Information Request: Multiple Acts

Veterans that fall under multiple acts should be given a choice. They should receive assistance in order to make that choice.

Section three: an alternative model

2.1 Introduction

Whilst I agree with the theory of a singled unified portfolio department, I would advise against some of the draft arrangements. For the ADF, it is about striking the right balance between functional and societal imperatives, between necessary capabilities whilst ensuring the welfare of individuals within the institution. This balance can be struck by counterbalancing the vertical power structures of the ADF with horizontal care structures facilitated by either the proposed VSC or the DVA. Horizontal care balances capability and wellbeing and focuses on continuity of care which is the key to ensuring the best possible outcomes for veterans and their families. This is achievable by balancing the effects of institutionalisation and creating a conduit for increased agency whilst still adhering to capability and command. It creates an environment where individuals are in an active state of transition throughout their military life and beyond.

2.3 An alternative model of care

An alternative model utilises supports that run horizontal to the different stages of service (in-service, transition, post service) within the Department of Defence. If the ADF cannot a reform – DVA would be best to administer the system to protect the welfare of individuals at every stage of the military life cycle. Therefore, either VSC, or DVA, would be responsible for administering the system. A model that includes horizontal structuring affords the opportunity to create a seamless system that is focused on wellbeing from the beginning of a member's military career due to the features of both unification and independence. Further, it balances capability against wellbeing and agency against limited agency. It would keep individuals actively engaged within wider society and would create the conditions for the transition process to begin from the first day in-service.

A horizontal care division requires two interconnecting pathways - health and wellbeing, with a focus on prevention. Preventative care is necessary to ensure the day to day wellbeing of personnel and vital support services within an institutional setting. Prevention and wellness balance the loss of agency within an institution. Supports should align with empowerment and self-sufficiency and not create dependency. This would assist in the reduction of high mental health rates and assist in the prevention of suicide – particularly for junior ranks and medical dischargees. Notably, horizontal care targets vulnerable populations whilst ensuring a standard of assistance for all. It creates resilience through greater autonomy and less co-dependency on the ADF which leads to better veteran outcomes and reduces overall costs.

It would be advisable to consider co-ordinating client contact through a reflexive case management model. The configuration of the case management structure would be determined by the level/type of care required plus the stage of the military life cycle. It is not intended to be a burdenous support but a structural capability flexible to individual needs and service requirements. Rehabilitation would fall under the health division. Transitions under the wellbeing division. The health division would focus on all facets of health including preventative care (in-service), rehabilitation (in and post service) and co-ordination of non-liability health care (post service). The wellbeing division would focus on vocation, transition, and psycho-social both in and post service. This model would:

- ensure continuity of care and ensure one contact point for personnel throughout the military life cycle
- ensure privacy for the individual (outside command)
- give the individual greater agency to make informed choices about their own health and wellbeing
- balance wellbeing and capability
- assist in a successful transition
- assist personnel to stay connected to society
- reduce costs and optimise results

- ensure the focus on 'return to work' from the outset which can be altered in the original plan if required
- ensure transparency and accountability
- report on outcomes to drive further improvements

The system would be administered in-house by either DoD or DVA. This would:

- rationalise and centralise documentation for compensation purposes
- optimise specialist care for the serving and ex-serving members
- ensure continuity of care and support
- foster trusting relationships between providers and members
- ensure privacy and agency for personnel in a civilian sphere
- ensure best practice
- ensure full transparency and accountability
- advocate and support individuals in their work environment ie. welfare boards and access to education/training
- coordinated rehabilitation assistance based on needs

What about Joint Health Command?

A horizontal system may require changes within the ADF JHC structure. Whilst it is paramount for ADF personnel to have a standard of 'readiness', this does not mean that the ADF needs to control every facet of an individual's health; all this does is compound poor veteran outcomes. Currently continuity of care is limited as JHC already outsources much of its capability, bringing services in house but under the DoD may be a viable alternative.
It would be interesting to see whether Joint Health Command could align with the purposes of Joint Operations Command; Joint Health Command could align with the management and assessment of medical fitness for duty and health within operational environments. Either way, there is a lot of interplay between capability, transitions, medical categories and a new flexible workforce structure that could be considered and explored.

What about medical standards?

As the ADF is moving towards a flexible workforce model, arguably, new standards could be devised that would incorporate medical category and Reserve time. This would also have the benefit of increased retention rates as personnel could be 'rehabilitated' into a flexible work environment and/or outside the strict requirements of command; a retention in knowledge within the employment pool would improve capability. As noted above, there is a lot of interplay between capability, transitions, medical categories and a new flexible workforce structure that could be considered and explored.

What about Joint Transition command?

A Command structure within the ADF is counterintuitive to assisting personnel transitioning smoothly. What is being asked is for institutionalised people to tell other institutionalised people how not to be institutionalised when they leave the institution. This would be particularly harmful for those undertaking a medical discharge. Notably, to medicalise or patholgise transitions is also counter-intuitive and would simply create another power complex for individuals to navigate.

A transition model should be focused on deinstitutionalisation and not reinforcing institutionalisation – particularly

close to discharge. Transition is about re-orientating to a new environment and not continuing in the same. A good transition model will assist in orientating members gradually and supportively to ensure positive outcomes. It will keep members connected with the military and wider society and create options and choice. Importantly, it is about understanding that personnel never 'return' to where they were because, as humans, we are in a constant flux of change. Re-orientation should be about empowering and educating individuals in how they are constantly moving forward, and how they can adapt and assimilate skills and world views that they have come to possess throughout their career within the broader context of society. It is not about fixing or returning but moving forward. A Command Structure does not liken itself to this model. Command would still have a key role to play.

Within the DoD, there are many uniform and APS mixed work spaces. It would be possible to post personnel to centralised 'transition cells' that would be formed and administered by the DoD. As a posting, personnel would still be attached to a command unit (this could ensure compliance), however, the command unit would have no authority over the workplace other than to ensure compliance and assist with administration pertaining to a member's discharge. As a 'posting' personnel would prepare for transition (between two-three months?). If personnel did not adhere to the requirements of the job (ie attending seminars etc), they would then be passed over to the attached Command unit for compliance.

As part of the proposed horizontal structure, transitions support would be administered by the DoD (or DVA) to ensure continuity of care. With a focus on prevention and protection against dependency and institutionalisation it would horizontally flow with the different stages of service (in-service, transition, post service) and focus on wellbeing from the beginning of a member's military career. Horizontal structuring assists transitioning as it balances capability against wellbeing and agency against limited agency. It would mean that Transition is a process that begins from the first day in-service.
This model would:

- Ensure transition into the military is smooth
- Assist members in navigating systems and rights and responsibilities
- Work as a single point of entry at the beginning of the military career cycle that would continue post discharge
- Build trusting relationships
- Provide individual support and advice for veterans on transitions, education, and career
- Include families and introduce members to ESOs early in the military life cycle
- Ensure that members receive holistic services that meet their individual needs, including information about, and access to VSC/DVA processes and services before transition
- Remain an assessible source for a defined period after discharge
- Prepare members for all aspects of civilian life, including the social and psychological aspects of transition
- Report on transition outcomes to drive further improvement
- Prepare serving members and their families for transition from day one of service
- Assist in the preparation of a career plan that covers both their service and post service careers (including education) and update that plan every two years

The VSC

Under the proposed arrangements of the VSC there is significant scope to incorporate the ESO and veteran community. Currently, the ESO space is an unregulated sector characterised by overcrowding, duplication of services and a lack of cohesion and direction. Arguably this is because they have limited research into the needs of the community they serve. Further, the ESO community is not representational of the veteran community with majority

of veterans, particularly younger veterans, not interested in participating. Whilst it has been argued for the sector to unify through speaking ‘with one voice’, this is counterintuitive to understanding the needs of the community particularly vulnerable populations who are often silenced by the power of politics. What is needed is co-ordination and direction, not unification.

Coordination could occur through the production of research. As one of the functions of the VSC is to ‘conduct or commission research into veteran issues’, the VSC could ‘develop appropriate means by which the Commission receives input and feedback from veterans and other stakeholders’ through input into yearly research agendas; research agendas would be set in-part by the VCS with other research set by the community. The findings of this research would inform policy change and ensure trust, accountability, and transparency between all stakeholders. It would give the veteran community a unified voice on a diverse range of issues. It would ensure that policy changes occurred out of need and not apparent need. This would also ensure due process instead of political persuasion.

The VCS could receive feedback and input from veterans and stakeholders symposiums. These conferences could act as the conduit for disseminating finished research and setting new agendas. Feed back and input could also be provided by way of submission. However, a care would have to be taken to ensure that research agendas balanced an over representation of some cohorts and under representation of others – particularly for the most vulnerable and hidden populations. A care would also need to be taken for research that was completely independent.

I would argue for an independent research facility within the VSC be set up and funded by the Commission. Its purpose to produce research on individuals and their families through every stage of the military life cycle including in-service. Research could be commissioned but overall control retained inhouse by a small group of researchers to ensure research is veteran-centric and methods of inquiry appropriate. Findings should be made fully transparent and published. I am unsure about the use of DDVA HREC, the Commission would need to make every effort to ensure that research was published in full to ensure validity and improve veteran outcomes.

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