Prepared by Dr Paula Dabovich PhD
Adjunct Senior Lecturer
School of Public Health
Visiting Fellow
Centre for Traumatic Stress Studies
The University of Adelaide

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Committee Secretary
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Thank you for the opportunity to provide this submission to the Productivity Commission's Inquiry into the Compensation and Rehabilitation for Veterans, which I make in a private capacity. By way of introduction I have completed a PhD (Medicine with commendation) in which I examined the rehabilitation and transition experiences of serving military personnel, using a public health lens (Dabovich, 2018). This work now underpins a tri-nation working group that seeks to improve transition and wellbeing outcomes for those who leave the Canadian Armed Forces on medical grounds. I am happy to provide the Commission with more specific details relating to this project, upon request. In addition, I am a member of South Australia's Veteran Health Advisory Council, Veteran Advisory Council, and have accepted membership with the Advisory Council for the National Centre for Veteran's' Healthcare, New South Wales. Concurrently, in my full time capacity, I am assisting a portion of the Australian Army better understand and meet the needs of members' families, using a public health approach.

With a professional background as an Army General Service Officer, Registered Nurse, and with a growing expertise in the field of Public Health in a military and veteran context, I offer this submission with a perspective that accounts for the human experience of those who leave the military on medical grounds, and an understanding of the pragmatic and complex task of government to deliver services that extend across federal, state, and community systems of care.

Background

It is clear, the challenge faced by the Commission is to propose a system of care that can support the unique health and wellbeing needs of veterans and their families as they transition from the military, and can continue to meet those needs, as they change over time. Those who are required to leave the military on medical grounds are extremely sensitive to the function or dysfunction of the system responsible for their care, as they simultaneously face stressors related to significant physical, financial and social loss. Unless managed well, the impact of these stressors may exacerbate existing mental health conditions, for which the commonwealth may become further liable.

It is striking that the in the current context, there are two health systems that are charged with the care of our veterans over time—the "military" system and the "DVA system" and that transitioning between them occurs during a period of heightened vulnerability—precisely when many wounded, injured, and ill personnel are least equipped to manage it. The Commission ought to be commended for acknowledging this issue which has impacted many generations of our veterans.

The current "military to DVA" health system was born of the early and mid-20th century's biomedical understanding of health. During this period, a person's individual parts tended to be isolated from the whole, their bodies were isolated from their minds, and people were considered as separate to their social world (McFarlane, 2017). For example, it was the function of a *limb* that was of concern (and compensated for) more so than the overall wellbeing of the person to whom the limb was attached. With such reductionist thinking, the previous "military to DVA" health system was fit-for-purpose.

The understanding of health has evolved enormously since the mid-20th century with conceptualisations of it extending from the disorder of a person's part, to their wellbeing as whole, as they exist in relation to their social environment, and most significantly, *over-time.* In the late 1970s this approach was conceptualised as the biopsychosocial model (Engel, 1977), which now underpins significant guiding principles in life-course and public health models globally (Henly et al., 2011; World Health Organization, 1978). It is to this understanding that advances in systems of care for our veterans are to be framed, if our nation is to create a structure that can truly meet the needs of our veterans in an economically sustainable way, both now and into the future.

The word "veteran" which is at the core of this inquiry, has come to hold different meanings to Australian society over the past 100 years. Throughout most of the 20th century, it was a term reserved for those who returned from war, however in the 1990s, it came to include those who had returned from warlike operations and peacekeeping missions. More recently the unique stressors of military service, including participation in border patrol operations, and the use of drone technology (in which military personnel can target and engage enemy forces without deploying), means the term has now come to include all those who have served at least one day in full time service. This change in definition is reflected in DVA policy that enables full-time military personnel and veterans access to non-liability mental healthcare. From an evolutionary perspective, this latest shift is significant because those in the ADF are now considered serving personnel *and* veterans concurrently, which provides clues as to what may constitute an effective framework for a progressive military to civilian healthcare and compensatory system.

The system and accountability

The productivity commissions report acknowledges the need to move toward a more cohesive and sustainable system of care for our military personnel and veterans. This requires moving from systems of care that have limited internal feedback-loops within their own organisations and with each other, to systems which are integrated, reflexive, and accountable.

Currently, the liabilities of the ADF (which may be understood in human or fiscal terms) are ultimately carried by DVA and the liabilities of DVA are met with an uncapped budget which is carried by the people of Australia. Ultimately then, neither the ADF or DVA have little organisational motivation to monitor, gain insight, or critically analyse their interventions of systems of care which may otherwise ensure best outcomes for our veterans and our nation. This situation represents a complete absence of clinical governance, which is remarkable given the high rates of distress experienced by our veterans (Van Hooff et al., 2018) and the degree of expenditure afforded to their care—a situation aggravated by the fact that many of the generalised psychotherapeutic interventions (which have been developed on civilians for civilians) are known to have poor rate of efficacy in military and veteran populations (Steenkamp, Litz, Hoge, & Marmar, 2015).

This submission does not propose either the ADF or DVA be capped in terms of the care it provides our veterans. Indeed, the demands of service in the ADF are unique and often expose our people to

circumstances above and beyond civilian comprehension. As a nation we must continue to honour this service and the consequences of it—but we must do it responsibly.

What is proposed is an integrated system that *acts* accountably through critically examining its internal systems and outcomes, measures them in humanistic (i.e. wellbeing)(Vogt, Taverna, Nillni, & Tyrell, 2018) and fiscal terms, and considers results in relation to community norms and expectations. Accountability may be generated from within or forced from without and because there is currently no coherent means of accountability in these terms from within, the Commission's recommendation to adopt an actuary model to prompt such organisational insight, has merit. If this model is adopted, the onus of governance must fall on Joint Health Command (in the hope it will prompt a critical analysis of the services they provide to support our people), rather than directly on the fighting force who already operate under rigorous OHS and risk-mitigation frameworks.

A combined military and DVA system

The Commission has articulated that one way to create a coherent system that accounts for the individual over time, and which may lessen the administrative burden of leaving the military with health issues, is to abolish DVA and transfer the responsibility of veteran policy to Defence and (presumably) health provision to the civil sector. In its current form, this shift may be problematic because the expertise available in Defence is not commensurate with what is required to develop and monitor policy that accounts for the complex and often chronic health issues experienced by our veterans across the life span. In addition, the civil sector (as it currently stands) does not hold the aetiological (causal) expertise or cultural competence which would otherwise help clinicians and lay workers better address and help veterans and their families manage their higher rates of chronic and complex health outcomes.

The current lack of expertise and cultural competence in relation to military and veteran health is problematic because both the current DVA system and that which may be created in relation to the Commission's insights so far, assume the expertise required to care for veterans exists in the community. However this assumption is based on the previously articulated biomedical model developed in the mid-20th century wherein veterans are reduced to their parts and without regard to the relationships and values developed in service, and further, how these (and changes in them) can and *do* impact their health outcomes during transition and over-time. In addition, the civil community does not provide the structure many veterans have come to rely upon in the military which helps maintain a degree of psychological organisation when operating amidst unstable environments. For those who have been exposed to trauma, either in the military or prior to enlistment, such structure is likely critical during transition and during other life stages (that may also represent instability)—which is something the civilian health sector, however well meaning, cannot provide. For these reasons, meeting the needs of our veterans, even under the current purchaser-provider model, remains so difficult.

An alternative to abolishing DVA, the Commission might consider a system that that both creates and integrates direct DVA health assets with those of the ADF. Such a system would ideally be based on primary, secondary, and tertiary levels of care. For example, whilst in service, the ADF would be required to provide serving personnel primary (or garrison) health support, in addition to the health services necessary for deployment (with a specialist workforce generated by the Reserve component, as per current practice), with secondary and tertiary healthcare being provided by direct DVA health assets (which would ideally also employ Reservists).

DVA healthcare would also support veterans and their families more broadly, as they address conditions associated with service. For serving members and veterans, these conditions are known

to include mental health problems, joint and mobility limitations, chronic pain, and later, chronic disease (DVA, 2017), whilst their spouses may benefit from mental health and relationship support (Lester et al., 2010; Turner & Chessor, 2015). Ideally and critically, such services would come to include a range of interventions that support (and connect) the children of our service personnel and veterans, who experience higher rates of hyperactivity, distractibility, emotional symptoms (such as anxiety or fearfulness), peer rejection, and bullying compared to their civilian counterparts (Daraganova, Smart, & Romaniuk, 2018; Esposito-Smythers, 2011; White, 2011; Chandra et al., 2010; Gorman 2010).

In such a system, serving personnel will enter DVA when they present with a condition that is serious enough to warrant secondary or tertiary examination or care, and which may therefore attract (what we now understand as) future liability. Entering DVA care therefore, will become a process that occurs during a career whilst a person is *mostly* well, rather than an event to be encountered during the sensitive period of transition. In this case, the only shift an individual would need experience between "health systems" during transition, would be from the garrison primary healthcare service to a family general practitioner (GP) in their anticipated local community.

A network of General Practitioners in the civil community

The concept of developing a network of culturally aware GPs (and other primary healthcare providers) who understand the impact of service on veterans and their families, and who are familiar with the DVA system, is not new. It has been offered in many professional and representative forums over the past few years. To date, this concept does not seem to have penetrated the military or DVA system, and if it has, it is not well communicated. The ability for Veterans and their families to connect with health professionals (especially during transition) who can contextualise and thereby help manage their distress or health issues, is likely to have a profoundly positive impact on long-term health and wellbeing. This service is more critical given the proliferation of GP super-centres in Australia, many of which may mis-represent what good care looks like and fail to provide veterans and their families with the contextual understanding and attention they may need and deserve.

A Transition Command

As may be gleaned from the all that has been stated and is consequential to the above, the difficulty with transition and veteran care across the lifespan is that it very complex. For example, at an individual level, transition sits at the intersection of a person's professional and private life—both of which are significantly disrupted; and at the systems level, it sits at the intersection of federal (i.e. Defence and DVA), state, and community health services. Because of this complexity we don't yet have the "system" right in Australia, because none of these levels of organisations or systems of care are charged with the *responsibility* of transition and therefore, there is no organisation held accountable for it. This must be challenged.

The commission has proposed a "Transition Command" within Defence and this may go some way in alleviating the question of *"who is responsible?"* for developing programs and measures that would better prepare and support our veterans as they adjust to civilian life; and upon which states, local communities, and organisations can build upon. This proposal has great merit which is reflected by fact that the Canadian Armed Forces have raised such a Transition Group as a part of their National Defence Headquarters, to meet the needs of their veterans in this context. In the Australia, such a command may also come to hold a level of expertise (which may be disseminated in the professional education of health providers) that could help cohere our veterans' service and post-service lives, which is the very essence of what is currently lacking in the current disjoined system.

Clinical governance

As previously stated, a system born of this Inquiry may be either *held* to an actuary model of accountability or be imbued with the resources and tools that would enable DVA and the ADF to *act* accountably, of their own accord. Either way, the existing or refreshed system must be founded on a rigorous longitudinal research agenda, which must have the capacity to monitor needs of serving personnel and veterans, ascertain the efficacy of treatments and healthcare interventions offered, and generate insights in both humanistic and fiscal terms. Monitoring of our veterans should continue for at least five years after service.

The long-term monitoring of these measures, which would essentially constitute good clinical governance, would ideally commence at the beginning of entry into the ADF. Indeed, research programs are already being designed and harnessed in relation through a Human Performance Optimisation lens, which aims to monitor, provide interventions, and improve individual function (and thereby collective capability). Given that function and dysfunction (or disorder) sit at opposite ends of the same spectrum, and that many service personnel will experience both these—especially in terms of cognition and mental health— there exists an opportunity to capture longitudinal data that may assist with both clinical governance and capability, with little extra resource.

Conclusion

When an individual swears an oath to the Commonwealth of Australia, they are swearing to ultimately put the nation's needs ahead of their own, which places enormous demands on both them and their families. For many service personnel, these demands include frequent postings and deployments, along with disruptions to social support systems, work, and school. For a few, demands include exposure to profound trauma and situations likely beyond the comprehension of most civilians which further complicate the experiences of transition and adaptation to civilian life—especially when this occurs on medical grounds. Because of all these factors, there is a need for our nation to develop a structured, cohesive, and accountable healthcare system that meets the needs of our service members and their families, both during service and after it. The current system, which is characterised by a sharp disjuncture during a period of vulnerability is not fit for purpose, nor is a system that lacks veteran health expertise in the civil community. An alternative system that has the capacity to help cohere an individual's service and post-service life, is reflexive and accountable, and can help veterans and their families navigate various life-stages, may go further to ensure their wellbeing, and the health of the Australian economy more broadly.

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