Royal Commission into Defence Personnel and Veteran Suicide

Warragul RSL Submission

Part 2 Australian Defence Force

A systemic analysis of the contributing risk factors relevant to defence and Veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation, and post-service issues, such as the following:

1. The ADF must focus, by necessity, on Operational outcomes. The role of the ADF is simply to win wars. Everything; selection, training, management, leadership is directed, or should be, to that mission.

2. In the last decade and a half that operational concept has been eroded by the "culture wars". Categorically, the ADF is not a social experiment. The operational imperative transcends the normal social standards in society. Through the lens of combat and training for combat the only thing that matters is winning! A bullet, missile, or a terrorist care not that your ADF is politically and socially correct. The only thing that matters is avoiding the bullet, missile or terrorist and killing the perpetrators. This is harsh, but to some the unpalatable truth. This ethos is at the core of successful soldiering and should not be tampered with under the guise of equity, diversity, or inclusion.

3. We argue that the fighting culture, warrior culture, team orientation and the will to win need to be inculcated from the first day in the ADF. When we were/are under operational pressure, we are all teammates! This is the business we are/were in, and we bring this necessary ethos to the RC table via this Submission. We need to make this military and operational imperative (imperatively) clear to the RC to ensure the ADF is not a vehicle for the social engineering movement to water down the ADF mission.

4. This RC should investigate this hypothesis due to the plethora of reports, notable among them is the Broderick Report, have distorted the perception of the mission of the ADF. Insidiously, we have allowed those standards and realities to be diluted. We contend that it has cost lives, caused injury both mental and physical. The responsibility for the legal, ethical management of soldiers to ensure that there are not excesses lies with the Leadership of the ADF.

The manner or time in which the defence member or Veteran was recruited to the [the Australian Defence Force (the ADF)];

5. Of frustration to the applicant is the length of time taken to be assessed as suitable before joining the military. Contracted out[1], the process lacks connection and the time taken is, as stated, excessive. There is also a lack of consistency with standards for example, a member who had a major knee injury at 14 years of age was informed that he was unable to join a combat arm and he was nominated for Signal Corps. When the member entered the military at 17 years of age and went through the training system he ended up as a Combat Signaller at 2nd Commando Regiment and undertook the extremely difficult Commando reinforcement cycle. He completed such things as parachute training and the full suite of infantry combat courses.

6. It is assumed that because the ADF did not take its own advice the ADF has now taken responsibility for the members knee injury.

7. In the quest for equity and diversity in the military, priority has been given to females in corps and roles for which they are not physically suitable[2]. In order to maintain a level of equity and diversity, some training institutions such as 1RTB have now a dual standard for physical training. Despite this, females are expected to carry the same loads as their male counterpart and endure the same training regimen. At the risk of taking feminist scorn, we are breaking females at a disproportionate rate to males because they are in unsuitable roles due to their physical structure and the requirements of the military, particularly the army[3]. See the Army Physical Training Regimen attached as Annex B.

8. The bottom line is, not only is service in the military physically and mentally tough, but we reiterate the certainty of injury. The physical entry standards have been lowered over generations commensurate with community standards. The outcome still requires a higher level of physical training and military training to become suitable and competent for ongoing operational training.

9. Where in the training iterations are the physical standards rectified if the candidate doesn't meet the standard? Initially they're found at Recruit training, IET training then Unit training. When the physical standards, particularly at the first two training iterations are not being met remedial training is instituted extending periods before graduation.

[1] Was manpower now ADDECO.
[2] The number of females who have been injured has increased exponentially since 2010, however, due to FOI and resistance from the ADF we are unable to give the exact number of female injuries.
[3] Female injury is not as prevalent in the RAAF as the Navy and the Army. Again, this is difficult to quantify due to restriction on data release from the ADF.

10. Failure to meet the physical standards is often accompanied by injury. Injury management has become "contracted out" and there is the stigma of failure being sent to an organisation that conducts remedial training. This creates a loss of self-esteem and a loss of cohort identity. In some cases, where the shortfall has not been rectified, the training liability is placed on the unit to which the service person is posted. This is a prime source of potential suicide and suicidality because these members are not being managed at the micro level by leadership and the leadership is unable to examine[4] the medical rehabilitation structure.

11. The period between 1995 and 2020, is our most intense operational continuum in our history. A numerically restricted defence force deployed on at least seventy-five (75) Operations[5], domestic and international in the period. The numerically restricted defence force sent members on multiple deployments. It was not unusual to find members being deployed ten (10) or more times ranging between four (4) and twelve (12) months. Prior to these deployments a training regimen occurs placing their member under extreme physical and mental stress, deliberately, to prepare for operations.

12. The leadership failure is that no Senior Officer of Star rank was prepared to put their career on the line and publicly denounce a government for this intense operational continuum. Our allies, the US, and the UK, had many of the star ranks resign in disgust and go public with their views on the lack of preparedness. Comparing our allies, there has not been a single star rank who has been sacked (as opposed to not promoted) for publicising in government circles the overuse of a small force in this period.

13. There will be a legacy effect. Those who were over deployed will be more susceptible to manifesting physical and mental injury, particularly as they enter their fifties and onwards. Government, ADF leadership are at fault and this RC should recommend the conditions to ensure that this cohort is properly managed.

14. Serving members have been well paid for these multiple deployments which to some extent has compensated them for their loss of family, their rights, and the incurring of injury. Whilst that compensation was welcome, the corollary of excessive deployments has seriously weakened the Veteran, their family, and their employability long term outside the military.

The relevance, if any, of the particular branch, service or posting history, or the rank of the defence member or Veteran;

[4] Due to availability of the specialists, privacy legislation and off-site clinics.
[5] At least that number but difficult to get the correct number due to security restriction. This number was taken from listed Operations from Google.

15. As noted in the text the RAAF is less injury prone than the Army and Navy. This is due to the roles, capabilities, and employments in the RAAF in that the majority are likely to be behind in formal locations i.e., camps. The Army and the Navy are forward deployed and regularly encounter the wide range of operational environments. These operational environments cause injuries sometimes suddenly and not related to combat operations, but due to training and the environment.

16. Some branches and units are more intensively trained both physically and mentally than others. Certainly, special forces and infantry-based organisations are required to have a greater level of fitness on entry, and they are required to maintain that level of fitness. Inevitably, injuries occur in these units at higher rates than others. Whilst physical training is emphasised, some units deliberately and in accordance with their operational requirement, also place exceptional stresses on the mental capabilities of the member. This is an historical characteristic. Some roles require an intensity over a long period, and this has to be trained or inculcated into the member. Combine these stresses with the physical stress over an extended period, there is a burn out effect. Some of these organisations are very sophisticated in their approach to the maintenance of these stresses, others less so. Such is the culture to excel to join these units that applicants and members will go to extremes to maintain the levels of physical and mental fitness required.

17. There appears to be no prejudice in relation to the rank of the person engaging in a training continuum, however, our experience is that the levels of sophistication and management are superior at Officer environments of all services. That said, there is a higher expectation of Officers at these institutions and at units to perform at a higher level to display their leadership capability. There is a difference between Officers and enlisted personnel in relation to treatment should an injury occur. Officers have tended to transition from service life to civilian life better than their enlisted counterpart and manage their injury entitlements more professionally. This is due to the fact that the officer is generally better informed that the enlisted counterpart.

18. Posting for both Officers and enlisted personnel is difficult to manage and be fair. Officers have a structured career outlined for about the first 10 years. In that period, they know they will be posted at least three times and deployed on operations if that is available. Enlisted ranks will tend to be promoted in unit and will remain in that unit for about five (5) years. Constant postings have the problem of family dislocation, unlike the early/mid twentieth century when single income families were the norm, spouses now have careers. Posting movements interstate tend to disrupt spousal careers. In some garrison towns such as Townsville and Darwin, Wagga, Toowoomba, spousal employment is difficult and career progressions are not enhanced. This causes strain on the family unit. To be frank, some of these garrison towns are not conducive to the member in the long term and are a major issue for members separating from the services.

The manner or time in which the defence member or Veteran transitioned from the ADF or transitioned between service categories;

19. Please see Part 5 Transition.

20. Suffice to say that Officers tend to transition better because they are qualified for a civilian occupation, and they have practised management. Up until 2016, the Australian Army removed itself from the National Training Standards and deliberately removed capabilities from courses so members could not achieve a civilian qualification. This cynical exercise was particularly prevalent in technical areas and the lack of National qualification is a singular morale issue and a cause of separation.

21. The tendency is when a member separates from the Military, their focus is on their next phase of life. Transition seminars were not taken seriously and were perfunctorily delivered as a result. This has been remedied to some degree.

22. Please refer to Part 3 DVA.

23. If a member is injured and spends some time in rehabilitation and the injury is deemed sufficiently serious to terminate service, the member tends to lose his support network and military identity. This is due to the fact that they are not managed closely and there is little or no feedback from the medical and leadership fraternity because the medical fraternity is not organic to the units and leadership loses focus on the individual. These circumstances have been shown to increase the chances of suicidality and suicide in the member.

The availability, accessibility, timeliness and quality of health, wellbeing, and support services (including mental health support services) to the defence member or Veteran, and the effectiveness of such services;

24. It is Warragul RSL's experience that due to the cuts in military logistic support that occurred between 2007 and 2014 had a major impact on the health management of service personnel and Veteran health. Contracting out medical services has caused leadership to lose the optic of subordinate health and there is no intervention allowed from the military for the management of the members. Up until around 1995, most formations and/or units had sophisticated medical support organic to that unit. Physical training tended to be planned and injury management had a unit focus. That does not occur in 2023. This circumstance is compounded by the fact that members, but particularly enlisted ranks self-manage via PMKeyS. Again, leadership does not have the intimate knowledge of the member due to this self-management.

25. Medical support tends to be off base and not timely. There is little or no intimate military knowledge from contracted practitioners of either rehabilitation or operational requirements. The quality of health support is commensurate with the civilian constraints of Medicare fees and the lack of timeliness of payment from the Commonwealth. In the mid-20th century, much emphasis was placed on wellbeing and quality via the use of religious representation. Again, these tended to be organic to the unit or at least on base availability. As in the civilian world, these capabilities have tendered to be neglected. Mental health support is very heavily strained, particularly in the garrison towns and military psychologists have been stretched beyond capability due to the intense operational continuum between 1995 and 2020.

26. It should be pointed out that every service person wants to be deployed. They will do anything including lying and covering up injury to get deployed. Leadership has tended to favour this culture via the use of waivers.

27. There is the stigma of admitting to mental health issues, although this is changing, however, if you are exhibiting mental health issues you are unlikely to be promoted or deployed or placed in the operational environment of your choice. You will be overlooked at selection boards and your career is virtually stalled.

28. For Veterans, the mental health assistance is very difficult to access particularly in a COVID and post COVID environment. Compounding that difficulty is the fact that in the regions DVA does not pay mental health practitioners equivalent to what they can receive in the private sector. Also compounding this availability is the fact that Veterans can be very difficult to work with. Open Arms, the DVA mental health network, reflects the paucity of resources in the regions and in the main limits itself to telephone consultations. In an emergency[6], the police when involved, will commit the Veteran to a hospital under the Mental Health Act. In the region and in Victoria there is a lack of emergency triage for Veterans.

29. **Legal Drug use in the military**. Keeping alert in an operational environment is one of the more difficult problems facing service personnel. In WW1 and 2 extensive and legitimately dispensed stimulants such as Benzedrine and Dexedrine were issued. Allied Pilot's in WW2 used these drugs regularly especially for long distance and night flying.

30. The German Army was notorious for the intense and extensive use of "speed" in WW2.
The Australian serviceman but particularly the RAAF pilots used these drugs in in conjunction with the RAF and USAF. There was limited use of legal drugs in Korea and the authors of this document have no knowledge of the use of legal stimulants in Vietnam and recent conflicts. That said stimulants were dispensed by USAF medical personnel in Iraq and Afghanistan particularly for use by aircrew at night.

[6] Warragul RSL has on at least 6 occasions been called upon to assist Veterans and their families in relation to suicide and suicidality and family violence due to the lack of regional support.

31. Across our service history the use of cigarettes has been extensive. Surprisingly cigarettes made a comeback during our recent conflicts. Why? Increased concentration, calming effects and staying awake. Legal, caffeine-based drinks were and are consumed in huge quantities to increase and maintain energy and remain alert.

32. Legal drugs such as Nurofen, Panadol etc are use so extensively by service personnel that the term "light fighter candy" has entered the military lexicon. The necessary use of prescribed and legal drugs must have a lifetime impact on service personnel and Veterans.

33. The Warragul RSL initiated a program to brief local social services, police and practitioners and assume the responsibility of being the first point of contact in an emergency with regard to Veteran health. An attempt was made to have VicPol SOP for assistance when Veterans were in or had publicly exhibited mental health issues. This plan was stopped at Victorian government levels, however, RSL Victoria is engaging with the State Veterans minister to have an SOP.

The manner and extent to which information about the defence member or Veteran is held by and shared within and between different government entities;
the reporting and recording of information, relevant to the mental and physical health of defence members and Veterans, at enlistment and during and after service;

34. It would be interesting to tally the amount of FOI requests in relation to this RC. Getting information and data from both the ADF and DVA formally or informally is extremely difficult. The data sought is not personal but neutral figures only. For instance, how many people are injured at 1RTB? What is their gender and age break down, how many people are injured at IET training etc.? This basic data is essential for planning and management purposes. We believe that this data is being deliberately withheld.

35. If we are to move forward in the suicide and suicidality health sphere of our service personnel and Veterans, this raw data must be made available to stakeholders outside the DVA and ADF. The data should be raw, and the analysis and interpretation left to the stakeholders and in this case see the Chapter on Transitions and appointment of a National Commissioner for Veterans.

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