

**Submission to the Productivity
Commission – Veterans Compensation and
Rehabilitation
Public Hearing**

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Preamble

Military ill-health is starkly different to non-military ill-health in a multitude of ways. The physical consequences of battlefield deployment (even during peaceful training exercises) often have life-long detriment. In the case of Vietnam Veterans exposed to dioxins these consequences are multi-generational as strong evidence confirms the mutative effects of Agent Orange and other agents used in this War (Binder & Campbell, 2004; Ngo, Taylor, Roberts & Nguyen, 2006). These effects are witnessed every day by the villagers in Vietnam (NGO, Taylor & Roberts, 2010). They are experienced by many children and grandchildren of Vietnam Veterans in Australia (Gough, 2013; Jacobs & McNamara, 1986). These dioxins and other environmental contaminants from more recent military activity (Middle East Area of Operations) are proved to alter genetic expression and the very structure of DNA and we know that these remain insidiously embedded in the genome for generations (Al-Hadithi, Al-Diwan, Saleh, & Shabila, 2012; Gore, Fenton, Chappell, Flaws, Nadal, Prins, Toppari, & Zoeller, 2015). Currently DVA only acknowledges the genetic impacts of these dioxins on the first generation offspring. This is an additional burden for many Vietnam Veterans today who were “sprayed and betrayed” as they cannot get recognition for their grandchildren. The psychological impacts are more difficult to assess and thus treat.

I have served briefly in the Australian Army Medical Corps. I have PTSD. My father is a Vietnam Veteran with PTSD and was sprayed with Agent Orange. My son has spina bifida. My daughter has social anxiety.

I have been the Queensland State Health Advisor for the Vietnam Veterans Association (VVAA). I have been an area Delegate for the RSL. I have represented the VVAA and children of Vietnam Veterans on the DVA Family Health Study (2014) for 6 years as a central member of the Consultative Forum. I have worked in the fields of Child Safety, Corrective Services, Disability Employment Services, Disability Services and Education where I have directly witnessed both the impact of, and the urgent need for the applications of this research.

Furthermore I have recently lead a suicide bereavement and postvention service in Rockhampton and provided interventions to numerous suicide ideation cases in current and recently discharged service-persons over the years. I am acutely aware of the substantial short-falls in the Central Queensland Region for supporting military individuals and their families both out of a domestic violence, self-harm and/or suicide situation and beyond, regardless of the outcome. Currently these services are only provided by community-based philanthropic organisations that admit to me they have little, if any, knowledge of the specific issues experienced by military families and their troubled member. I have

worked as a case manager for many of these local organisations, and none (to date) admit they have any real idea how to account for these issues that differ vastly from those reported in the civilian population. This ignorance further fuels the growing frustration, resentment and distrust military communities have in civilian-oriented health services in this region which, in turn, may be a significant contributor to the incidences of self-harm, domestic violence and even suicide in the military population. Indeed there is a notable paucity of culturally relevant and meaningful general and mental health supports and services in the Rockhampton and Central Queensland Region that meets the needs of the military community that resides here. There is some irony in this due to Rockhampton having a military base.

Based on over 35 years of research and practical applications of my studies into the neuroepigenetic intergenerational impacts of traumatic stress, working within military communities and my own lived experiences, I make the following suggestions to the Productivity Commission.

Suggestions to the Productivity Commission.

1. **Shift of focus to measuring Outcomes, not participation.**

1.1. DVA/Defence should focus on measuring outcomes of treatments, not merely participation rates, to evaluate efficacy of all its services and products (including case management).

Veterans and their family members are not wishing to repeatedly attend Occupational Therapy sessions or Psychologist sessions or other allied health sessions. They want to get well again.

Therefore the focus of measurement that evaluates both the Veteran's entitlement to support and services (or compensation) is not on their ability to attend appointments, but on the collective outcome of those appointments. It should be a focus on the system that is purported to support the individual health-seeker, not on the individual's ability to attend a multitude of appointments that assess their ability to attend appointments. This in itself is meaningless to long-term optimal outcomes and is frankly ridiculously costly to taxpayers, unproductive, punitive to the Veteran and only contributes to the problem, not the solution. Only the provider benefits.

1.2. This shifts the focus for effectiveness on to the health provider to provide individually-tailored optimal quality supports (as in NDIS) rather than full onus on the Veteran. It enhances the likelihood that health providers will improve the quality of services to Veterans and their families to ensure they attract business from the Veteran community. Currently, many of those providers that are endorsed by DVA are reported by Veterans and their families over the years

to me to *not* be providing optimal quality services as they are in a monopoly or controlled situation. As one previous speaker here today [at PC public hearings in Rockhampton] stated, DVA is their “grave train” as he described the less-than-suitable support services he and his recently-discharged son had received from DVA-authorized health practitioners. Veterans and their families are expressing increasing frustration that they have to repeatedly “prove” their impairments to ignorant or negatively-predisposed providers. This oppresses a sense of “guilty until proven innocent” on the Veteran and their family, who is already burdened by their impairments.

- 1.3. A “Veteran-Directed” approach will assist the implementation of this proposed shift in focus, providing a sense of re-empowerment and sense of purpose in their own path towards positive health. Current preference to a “person-centred” approach that is promoted by the vast majority of civilian community-based services still does not fully enable the person in need of supports. It places them in a chair in the centre of a circle-of-support with providers discussing the person’s issues among themselves with little or no determination from the person. It retains a disempowerment function. A Veteran-Centred approach will ensure optimal contribution (not just participation) from the Veteran and their family (including formal and informal carers) in determining the most meaningful approach to optimally managing/resolving the Veteran’s and their families issues in the most cost-effective, time effective and resource-realistic way. Understandably, in cases where the Veteran is unable to self-determine their supports, the person-centred approach becomes the next favourable strategy.
- 1.4. The above strategies, if implemented fully and effectively, may ultimately significantly contribute towards the functional operations of the agency that eventually oversees the meaningful and purposeful rehabilitation of Australia’s military veterans and account for the impacts their military service experiences has on their families.

2. Staffing

- 2.1. It is critical the agency that eventually handles Veterans’ health employs assessors/Case managers who have lived experience of military service. Receiving advice and judgement from someone who has no understanding of the impacts of military service is like getting marriage-guidance counselling from someone who has never been married. Therefore each staff member who manages a case for compensation and/or rehabilitation should have a demonstrable understanding of military service – lived experience preferably – and not purely

in an officer's role where exposure to battlefield conflicts was limited, if occurred at all.

However, it is acknowledged that a person meeting these criteria may not be available in some geographical locations and a "next-best" strategy applies. They may also qualify through having lived experience as a direct member of a family (child, grandchild, partner, parent). This is clearly illuminated as a priority in the DVA's report on their national study into the health and wellbeing of Australia's Vietnam Veteran families (2014).

2.2. Whole-of-Family Assessment and Review. As it has been reported in studies by the Partners of Veterans Association (Outram, Hansen, Macdonell, Cockburn, & Adams, 2009) and in the Vietnam Veterans Family Health Study (Forrest, Edwards & Daraganova, 2014) the Veteran themselves is often unaware of their problematic behaviours that disrupt the daily functions and long-term development of each member of their family. These studies demonstrate that the perspectives of the Veteran's partner and children (including those from previous marriages or unions) are critical inclusions in any assessment. Assessors and Case Managers must interview the whole family directly affected by the Veteran's service. This will ensure a thorough, holistic view of the *real* struggles and challenges, victories and achievements are examined in light of their claim for supports. It will also more clearly reveal the level of supports needed and include the needs of the Veteran's children and grandchildren and their respective partners who may have been impacted by the Veterans' service. Again, this is clearly illuminated as a priority in the DVA's report on the health and wellbeing of Vietnam Veterans families (2014).

3. Prioritising of Cases – First Response.

3.1. A system of priority listing of urgency in cases presented to DVA must be implemented to reduce fatalities by suicide and incidents of self-harm, or, at worst, harming others (such as the frustration that leads to domestic violence, abuse and neglect). Similar to a hospital triage unit, urgent cases may be seen before non-urgent cases where either the Veteran or their dependents may be at eminent risk of harm. In these situations a local health representative familiar with Australian Military culture may be deployed to assess and intervene. This may also be a suitably trained member of an existing ex-military support service such as Vietnam Veterans Association or RSL as a First Responder with cultural understanding. A suitably qualified and trained representative will be able to rapidly assess severity of intervention required and be able to most accurately interpret intention, method and even extent to which

the crisis situation requires additional supports and follow-up services post-crisis. This will further foster the brotherhood of support among the services and reduce cost for the Department/Agency that inherits oversight of the administration of these functions.

- 4. Public hospital admission centres.** Hospital admission centres need to be educated on specific manners in which to approach crisis cases involving Veterans and/or their family members, and how not to approach them. Cultural insensitivity by emergency unit hospital staff has been demonstrated to adversely affect the health and recovery of other cultural groups. Military families are no different. Awareness of the intensity of the experiences of war, aggravated violence and intergenerational unexplainable health abnormalities that are commonplace reports for military veterans and their families presenting at public hospitals, may not be understood by emergency staff. This not only relates to mental ill-health and suicidation, but to physical health issues as well.
- 5. General Practitioners, Counsellors, Psychologists and other allied health professionals** working with Veterans and their families need to be educated on identifying and accounting for the range of cultural aspects to being a Veteran in an increasingly disapproving society. This includes the specific nature of the unique aspects to shame, guilt and doubt that detrimentally confronts their sense of autonomy and control, creating a state of intense conflict, resentment and, possibly, retaliation. Disempowered Veterans and family members overwhelmed by rejection and mismanagement eventually exhaust their resources to the extent where there is only one final conceivable solution. The current system is substantially responsible for this, and can be the solution with a rapid and simple conceptual shift. There is a noted paucity of compassion and acceptance among health practitioners regarding the anomalous range of problematic health issues reported by Veterans and their children. This paucity has been reported by Veterans and their dependents to myself and many welfare and advocacy officers over the years and is noted in the Vietnam Veterans Family Health Study (Forrest, Edwards & Daraganova, 2014) and in O'Brien (2011). A case example is daughters of Vietnam Veterans with Polycystic Ovarian Syndrome and other significant reproductive conditions that have no apparent causative factors. Personally my professional experience describes ongoing debates with mental health practitioners relating to the genetic and epigenetic impacts of military trauma on the neurological and emotional development of young people raised in military families. The struggle is to convince them to accept mounting evidence from the emerging scientific field of epigenetics that the environment determines genetic expression which shapes behaviour –

especially a person's response to stress. Data on the health anomalies in children of Middle East Veterans was not available at the time of writing of this Submission.

6. Genetics and PTSD

- 6.1. Mounting evidence from a widening variety of scientific sources identifies genetics and environmental impact on genetics (Epigenetics) as having significant implications in the acquisition of, and intergenerational transmission of traumatic stress. The tsunami of corticotropic steroids that flood the neurological defense systems further result in the alteration of the expression of specific genes at critical times of development: it can turn genes on or off, or alter the timing of their expression. This is shown to result in emotional dysregulations such as Autism, ADHD, Aspergers, Bipolar, Schizophrenia, Depression and Anxiety, Conduct Disorders and more. Further evidence demonstrates it piggy-backs on testosterone resulting in more boys being prone to emotional vulnerabilities than girls.
- 6.2. Therefore, as the evidence grows of a genetic component to consequences of traumatic stress, we urgently need to develop and implement a range of management and treatment programs that consider these genetic and epigenetic aspects. These must consider that biological bases for behaviour cannot be simply unlearned or replaced with an alternative behaviour. Genetically-moderated stress responses will endure over cognitive and/or behaviour moderated ones due to their underlying predetermination. For example, Strawbridge and colleagues (2018) demonstrate that a significant psychological trauma experienced in early life alters genetic phenotypes resulting in high-risk behaviours. This strongly demonstrates a growing awareness among mental health practitioners that strategies which neglect to incorporate genetic factors of trauma-related behaviours are short-term measures and are likely to ultimately fail.
- 6.3. Thus **a life-stage approach is required to account for the variances in genetic and epigenetic aspects of traumatic stress**. As testosterone and other hormone precursors are intimately involved in the stress-response, different strategies need to be developed and applied for each major life stage that is mediated by hormone changes. Adolescence is one such stage. Pregnancy is another. Later life, (commonly termed "mid-life crisis – where testosterone production in men decreases and increases in women) is also another. This has been described and proposed in a comprehensive report on the lived experiences of PTSD from the perspectives of children of Vietnam Veterans (O'Brien, 2011).

7. **Civilian Employment and PTSD** - optimal transition based on qualities, not just skills alone.

7.1. This requires educating employers at local community levels on the benefits of hiring ex-military personnel AND THEIR PARTNERS AND CHILDREN. This can be achieved with support from local Senators and Councilors in partnership with Defence and local ex-service organisations. Re-empowering a Veteran with a sense of purpose will have highly positive outcomes for their mental health through social and economic contributions and engagement, wellbeing and focus and a feeling of being needed again. Often the skills of a soldier (particularly Special Forces) are not typically valued by civilian workplaces. They are misunderstood and misinterpreted as having little or no validity, except on the battlefield. Employers who are educated in the benefits to productivity, operational efficiency, risk and loss mitigation and system optimizing will surely value the qualities that military service provides to Veterans, and, by association, their partners and children.

8. **Children raised in Military Families where PTSD is a Dominant Influence on Development**

Research by O'Brien (2005, 2011) and Forrest, Edwards and Daraganova (2014) demonstrates the profound impact of PTSD on the home, school and social environment in which children develop and derive meaning from their interaction with others and with their environments. O'Brien (2012) further presented evidence for neurological and genetic differences that contribute to dysfunctions reported by children raised in military families where PTSD was a dominant, invisible, ever-present factor in their development of identity and self and how these interactions can lead to a myriad of secondary, consequential impacts of PTSD through a social feedback loop. The following suggestions are derived from this evidence.

8.1. **Schooling** – Children derive a substantial component of their identity from their interactions with the education system and their peers. Dysfunctional environments will create dysfunctional children who grow to become dysfunctional adults. Children from PTSD affected military families have a perspective of the world around them – and their understanding of their place in that world – that is different from non-military children and even military children where PTSD is not a contributing influence (O'Brien, 2005). A rapid and simple solution to begin to address this is to educate school counsellors on identification and optimal support to reverse

the paradigm of ill-health towards valuing the qualities of their condition/situation, and to implement a positive awareness campaign that destigmatizes all mental ill-health and persuades a reframing of mental illness and military service in general.

8.2. **Social participation.** Creating meaningful opportunities for veterans, ex-military personnel and their partners and children to contribute to local communities through volunteering, social participation in sporting and community events has positive ramifications for all parties invested. However, this can be optimized through a broader public awareness campaign that illustrates the benefits of inclusion of military families in such settings. This campaign can focus on how military life can complement and contribute to community wellbeing, which, in turn, contributes to Veteran wellbeing, which contributes to family wellbeing. The cycle is self-perpetuating.

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This concludes the suggestions presented to the Productivity Commission.

It is hoped that the Productivity Commission will give reasonable consideration for these recommendations on how it may provide enhanced, improved and optimal services and supports for Veterans and their families in compensation and rehabilitation. Implementation of these recommendations is firmly anticipated to reduce long-term cost expenditure and economic mismanagement of funds on an antiquated, irrelevant system that has demonstrated it contributes to the ill-health of Veterans and their families, rather than producing improved health and wellbeing. The anticipated outcomes are multi-dimensional and positively impact on several social structures simultaneously with sustained ripple-effects into other no-military social systems.

Military families are the true backbone of freedom in our country for it is their sacrifices both on the battlefield and off, that defines the average Aussie and carves our identity as "the Lucky Country". In truth it is not by luck that we enjoy our relative freedoms and ability to pursue our ambitions. It is by sacrifice, service and determination that forges our national identity. We owe much to Veterans and their families. Continued neglect and ignorance of the growing struggles of Australia's military families, present and future, will only result in this luck evaporating.

Thank you for the opportunity to present my contributions.

Sincerely

Dr Kenneth J. O'Brien.