RSL Australia
Legacy Australia
Defence Force Welfare Association
Defence Reserves Association
Women Veterans Australia

Joint Response to the Defence and Veteran Mental Health and Wellbeing Strategy Exposure Draft

March 2025

Contents

Foreword

Five of Australia's leading Ex-Service Organisations (ESOs) have collaborated to provide this response to the *Defence and Veteran Mental Health and Wellbeing Strategy 2024-2029* (the Strategy) Exposure Draft. Our aim is to clearly outline the necessary actions required by DVA and Defence to safeguard the mental health and wellbeing of current and former veterans and their families. We support the goals of the strategy and believe that with some additions and a stronger connection to the Royal Commission outcomes, the Government can develop meaningful and robust action plans to achieve the stated goals.

The Returned & Services League of Australia (RSL) is the nation's largest ex-service organisation (ESO) which seeks to promote the interests and welfare of serving and ex-serving Australian Defence Force members, and their families. The RSL comprises seven state and territory branches, 1,095 sub-Branches and 149,000+ members nationwide. Since our establishment in 1916, the RSL has been advocating for benefits, treatment and the welfare of ex-serving and serving members of the ADF and leading the country in commemoration of military service.

Legacy Australia is an iconic Australian charity dedicated to supporting the families of deceased and seriously injured veterans. We are one of the only organisations in the world that does this important work. For over 100 years, Legacy Australia has helped hundreds of thousands of Australian widows, families and children of soldiers who have lost their lives or health during or following service in all conflicts since World War I to Iraq. Through its 45 clubs and with the help of a group of over 3,000 dedicated volunteers, known as Legatees, Legacy Australia currently cares for more than 30,000 beneficiaries across the nation including widows, 1,400 children and youth (0-26 years) and 900 beneficiaries with a disability.

The Defence Force Welfare Association (DFWA) is an Australia wide organisation, formed in 1959, for the purpose of promoting and protecting the welfare and interests of serving and former members of the Australian Defence Force and their families. Our advocacy areas include rehabilitation of injured veterans, compensation for service-related injuries, ADF pay and conditions, retirement and superannuation, improving service delivery, and veteran recognition.

The Defence Reserves Association (DRA), a joint organisation, is the only advocacy group specifically representing Defence Reservists. The major objective of the DRA is to represent the interests of Defence Reserves to promote an effective ADF and improve outcomes for former ADF members, by:

- providing advice to Government to inform legislative change, policy development and decision making;
- assisting the ADF in developing and implementing effective workforce management processes and conditions of service;
- engaging with stakeholders, including other ex-service organisations, in improving the welfare of and support to Reservists.

Women Veterans Australia is a dedicated Australian not-for-profit charity focused on supporting the well-being of women veterans. We provide funding and grants for programs

that promote their health, education, and empowerment, specifically addressing challenges unique to their military service or transition to civilian life. Through advocacy, training, and research, we aim to amplify understanding of these issues and ensure women veterans receive the recognition and support they deserve. Our mission is to help women veterans achieve their full potential, advocating for their needs and well-being at every step.

The ESO community has evolved over time to meet the needs of each generation of servicemen and women and deliver a diverse range of services across the domains of wellbeing, including education and employment, urgent financial assistance, and veteran homelessness. They also provide focal points for communities to gather, reflect and commemorate, as well as provide social connection. This paper provides a number of suggestions that, if included in the Strategy, will ensure tangible and measurable outcomes for veterans while also driving the implementation of the Royal Commission recommendations as previously agreed by Government.

Introduction

The veteran community appreciates the opportunity to contribute to the proposed joint *Defence and Veteran Mental Health and Wellbeing Strategy 2024-2029* (the Strategy), noting that it follows on from the previous *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023.*

Since the drafting of the previous Strategy and Action Plan, a *Royal Commission into Defence and Veteran Suicide* (Royal Commission) has been conducted and concluded on 9 September 2024. The Royal Commission considerations extended beyond defence and veteran suicide, and submissions addressed themes such as military service, trauma, mental health, family support, and systemic challenges, barriers and failures. The three-year inquiry is the most comprehensive consideration of defence and veteran mental health and wellbeing and the impact on their families ever undertaken in Australia.

Noting that the Government has agreed, or agreed in principle, to 104 of the Royal Commission's 122 recommendations, we advocate that development and delivery of a joint Defence and Veteran Mental Health and Wellbeing Strategy must necessarily be informed by the evidence and submissions provided to the Royal Commission and it must clearly identify how it will enable implementation of the accepted recommendations.

In making this submission, we give emphasis to the following finding of the Royal Commission:

> *'The establishment of this Royal Commission can be seen as a clear signal of the failure of successive governments, the ADF, the Department of Defence and DVA to learn from the lessons of the past, to implement the reform required to effect real change, and to adequately address the needs of those who serve our country.'*[1]

We advocate that the Strategy requires further thought to more appropriately address the recommendations of the Royal Commission in order to create a robust fit-for-purpose framework that will enable action to tangibly and sustainably improve the mental health and wellbeing of current and former serving members and the broader Defence community.

The inclusion of the Australia Public Service (APS) workforce within the Strategy is a welcome step, particularly as many veterans transition into APS roles. The Strategy also acknowledges the increasing integration of Defence, APS, and Industry personnel. However, there is little guidance on how APS members can access the services briefly mentioned. While this may be a more tactical consideration, it would be useful to clarify how their inclusion is operationalised beyond a diagram and a few paragraphs.

While the Strategy outlines a research-based approach, it lacks a clear gender-based focus on supporting mental health and wellbeing. Reports indicate that many women veterans experience feelings of invisibility or a lack of value simply because of their gender. The Strategy in its draft form does not adequately incorporate a gendered approach to supporting mental health and wellbeing outcomes, nor as it relates to the recruitment and

[1] Commonwealth of Australia, Royal Commission into Defence and Veteran Suicide, Final Report (2024) vol 1 [6].

retention of women in Defence. Without an integrated approach, Defence may struggle to meet its diversity goals.

In a similar vein, while the Strategy includes defence families and veteran families in its definition of the Defence and veteran community, apart from a vague mention that families are there for every stage of the Defence and veteran journey, they are mostly overlooked.

The Royal Commission spoke at length of the importance of family support to the mental health and wellbeing of both Defence members and veterans. It went further to acknowledge the mental health and wellbeing challenges of family members derived through supporting their veteran family member. These partners and children have also been affected by the service of the veteran and need to be considered within this strategy.

Families are key stakeholders who can detect early warning signs of distress and can benefit from tailored programs, especially during times of significant change (e.g., deployment, relocation, transition). The separate Defence and Veteran Family Wellbeing Strategy 2025-2030 is acknowledged, but it does not address the mental health issues raised in this accompanying strategy. If this strategy glosses over the importance of families, so will the ADF supervisors and public servants responsible for its implementation.

Additionally, the role of ex-service organisations (ESOs) within the Strategy remains unclear. The Strategy fails to account for the evolving nature of the ESO landscape and it is not clear how ESOs will be included in consultation, engagement and delivery of the goals.

Regarding monitoring and evaluation, to ensure success, we believe that individual appointments and positions should be held accountable for specific areas within the strategy. This could be identified in action plans and the accompanying monitoring and evaluation frameworks. Leaving accountability at a departmental level risks a lack of ownership and follow-through.

Finally, it would be remiss to not acknowledge and address the difficulty in achieving national mental health and wellbeing outcomes when health service delivery falls within the jurisdiction of states and territories. With COAG disbanded in favour of National Cabinet, how will the government galvanise action across jurisdictions to achieve the stated objectives of the Strategy? This potentially could be supported through the establishment of the Defence and Veteran Wellbeing Agency or the Defence and Veteran's Service Commission. This must be articulated in the Strategy, particularly as it relates to Goals 2, 3 and 5 which will by necessity require effective service delivery to be successful.

The veteran community provides the following commentary to inform further development of the strategy and stands ready to support the necessary development of accompanying action plans.

The Royal Commission into Defence and Veteran Suicide

It is noted that the Department of Defence and the Department of Veterans' Affairs have worked together to develop the joint Strategy. The Strategy aims to improve the mental health and wellbeing of the Defence and veteran community.

The Strategy sets out the joint approach of the Department of Defence (Defence) and Department of Veterans' Affairs (DVA) over the next five years to promoting and supporting wellbeing, through early intervention, prevention, timely access to care and support, and a positive and connected community, while focussing on suicide prevention, and using data to drive positive outcomes.

We note with concern the comment at page 2 of the Strategy:

'We acknowledge the work of the Royal Commission into Defence and Veteran Suicide. The recommendations from the report have been mapped to the goals of this Strategy. Given the large number and complexity of the recommendations, only a few recommendations have been specifically included in this Exposure Draft for illustrative purposes. We will continue to reflect on the insights and reports from the Royal Commission's work as we shape our suicide prevention initiatives, programs and services.' [2]

The Royal Commission inquiry and subsequent recommendations are to date, the most definitive and clearly articulated findings put forward to address the issues confronting serving and former serving members and their families. The report draws on research that identifies at-risk groups and the various factors that can contribute to a person's suicidal distress throughout their service and post service journey. A detailed examination of military-related risk and protective factors and stressors for serving and ex-serving members is set out in Volume 2 Serving the nation; Volume 4 Health care for serving and ex-serving members and Volume 5 Transition and support for ex-serving members. Volume 6 addresses the importance of families as a protective factor and the engagement with families in help-seeking, treatment and recovery. It also acknowledges the impact of service on families.

Put simply – the report by the Royal Commission should not be a document which is simply 'acknowledged' with some insights reflected upon. As stated previously, Defence and DVA have agreed to deliver on most of the recommendations made by the Royal Commission. We urge that the findings and recommendations of the Royal Commission form the core of any ongoing strategy to address the mental health and wellbeing of serving and former serving members of the ADF.

Further, the *Defence and Veteran Mental Health and Wellbeing Strategy 2024-2029* should be viewed as one of the main drivers of implementation of the Royal Commission recommendations. Rather than a piecemeal approach, using the Strategy to drive the

[2] Department of Veterans' Affairs, *Defence and Veteran Mental Health and Wellbeing Strategy 2024-2029* (Exposure Draft, Strategy Paper 28 January 2025) [2].

Government's response to the Royal Commission allows for a joined-up proactive approach that can be monitored and reported on over the course of the Strategy implementation.

It is noted that the draft document under consideration represents a 'high level' examination of how the Government may foster 'a culture that empowers and supports mental health and wellbeing'[3] including a table of the 'expected outcomes of the strategy'. It is unfortunate that the proposed strategy makes very limited attempt to identify how the Goals that have been identified may be achieved – even though the Royal Commission has made some clear recommendations which the Government has agreed to. These will be explored in detail in the remainder of this submission.

It is proposed that the strategy can be strengthened through the inclusion of details on identifying how success will be achieved – and very importantly, how any outcomes will be measured and reported upon.

Call to Action

To ensure success of the Strategy, we ask that

- the Royal Commission Recommendations are directly referenced in the Strategy where relevant and are used to inform robust action plans that can be monitored and evaluated.
- it is clearly articulated how the National Strategy will be implemented across jurisdictions.
- the Strategy include clear reporting lines to enable the sector to monitor progress against the action plans and they must be in place for sufficient time to ensure continuity and effective monitoring.
- there be consistency across Defence and DVA in evaluation and reporting frameworks.

[3] Ibid [4].

Goals

The Draft Strategy identifies six goals that will be the focus of the joint action of Defence and DVA.[4]

- Goal 1: Promote and assist wellbeing
- Goal 2: Improve mental health and wellbeing through prevention and early intervention
- Goal 3: Facilitate timely access to quality care and support
- Goal 4: Grow a positive and connected Defence and veteran community
- Goal 5: Prioritise suicide prevention initiatives
- Goal 6: Use evidence and data to drive positive outcomes

These goals are included as a high-level end-state intentions which are fully supported by the veteran community. However, in comparing the 2024-29 Strategy to the previous 2020-23 Strategy, we note the absence of an action plan to support these goals. We suggest that it would be appropriate to map the recommendations of the Royal Commission against these goals in a detailed action plan or plans, to uphold the Government's agreement to implementation and to support reporting on the progress of implementation.

Further, the action plans and evaluation framework should include original statistics for benchmarking, and they must be consistently applied across both departments and be in place for a minimum period to ensure continuity and effective tracking.

We suggest that implementation, monitoring and evaluation of the action plan/s and overarching Strategy, could be achieved in part through the establishment of a new agency to focus on veteran and family wellbeing. Noting however, the Strategy applies to veterans and their families, serving members and their families, and public servants, which may fall out of scope as outlined by the Royal Commission in Recommendation 87 *establish a new agency to focus on veteran wellbeing*.[5] We note that the Government has taken some steps to establish a new agency within DVA and encourages greater transparency of this decision making, including clear communication to the veteran community about the scope and operations of the new agency.

The veteran community stands ready to support the development of action plans, drawing on the Royal Commission findings, that will ensure the overarching strategy can guide meaningful outcomes that are tracked and measured.

Call to Action

To achieve the Goals of the Strategy, we ask that

- the ESOs are invited to inform the development of action plans that are mapped against the Royal Commission recommendations.
- action plans are supported by a robust evaluation framework with evidence-based, data driven benchmarks.

[4] Ibid, [10]-[14].

[5] Commonwealth of Australia, *Australian Government Response to the Royal Commission into Defence and Veteran Suicide* (Response Paper, 02 December 2024) [109].

Goal 1: Promote and assist wellbeing

The Royal Commission found that organisational culture can strongly affect mental health and wellbeing and act as risk factors for suicide and suicidality.[6] *Volume two* of the final report *Serving the nation, and Defence culture and leadership*[7], includes 13 recommendations that will facilitate a culture change within Defence, leading to better mental health and wellbeing outcomes for veterans and serving members. Conversely, *Volume 5: Transition, DVA and support for serving members*[8] provides tangible recommendations to support health and wellbeing of veterans as they transition from Defence into civilian life. The Government agreed or agreed in-principle with all recommendations in these two sections of the report and where relevant, those recommendations should be referenced in this goal or in an accompanying action plan.

The five objectives identified as drivers of this goal align well with many of the Royal Commission recommendations. A comprehensive action plan for Goal 1 could be developed by drawing on the specific recommendations contained within the final report and the Government response to the final report. For example, Recommendation 2[9] which targets new recruits, Recommendation 5[10] to bolster the mental health and wellbeing branch of DVA, and Recommendation 9[11] which speaks to culture and leadership accountability.

In fact, Recommendation 79[12] mirrors one of the wellbeing factors: 'recognition and respect', and Recommendations 84[13] and 85[14] align with wellbeing factor 'employment and meaningful activity'. These are just examples of where there is clear congruence between the objectives of the Strategy and the Royal Commission outcomes.

DVA has commenced work to support the implementation of some of the Royal Commission Recommendations, but it is not clearly articulated how this aligns with the Strategy. As touched on previously, the proposed new wellbeing agency could support a cohesive and transparent implementation of both the Royal Commission recommendations and the Strategy.

> *Call to Action*
> We call on the Strategy to acknowledge the work already being undertaken in response to the Royal Commission, and to commit to delivering on a process which focusses specifically on veteran wellbeing including the future steps to be taken.

[6] Above n.1, [16].
[7] Above n.1, vol 2
[8] Above n.1, vol 5.
[9] Recommendation 2: Improve outcomes and access to support for recruits in abi initio training Ibid [96]
[10] Recommendation 5: Support al serving members to decompress, rest and reintegrate, especially after high-risk experiences. Ibid [98]
[11] Recommendation 9: Improve organisational culture and leadership accountability to increase member wellbeing and safety. Ibid [100]
[12] Recommendation 79: Ensure that respect for and recognition of service are embedded throughout Defence and the Department of Veterans Affairs. Ibid [143].
[13] Recommendation 84: Issue separating members with a refence that states their skills, experience and capabilities. Ibid [146]
[14] Recommendation 85: Develop employment pathways for ex-serving members in public sector agencies. Ibid [147].

The bulk of this section focuses on serving members themselves (including recruits and transitions) without consistently highlighting how families might be supported under the same initiatives (e.g., how to offer respite or help families navigate complex systems).

In discussions of "culture change" within Defence, they must explicitly include family outreach and training resources for partners and children, particularly for mental health literacy.

When mentioning "pre- and post-deployment," the Strategy must incorporate a direct reference to support mechanisms for families, such as resources to prepare spouses/partners for changes in behaviour or mood.

Goal 2: Improve mental health and wellbeing through prevention and early intervention

Whilst Goal 2 does refer to the Royal Commission recommendations[15], the Royal Commission has also made a number of relevant recommendations in *Volume 5: Transition, DVA and support for ex-serving members.* In particular, Recommendations 79 to 85 outline steps in ensuring a supportive and positive transition from Defence. The Government has either agreed or 'agreed-in-principle to all recommendations in this volume[16].

Again, a robust action plan could include additional measures that will strengthen the intended outcomes. In recognising the value of building help-seeking behaviour and peer support across all ranks of services, we suggest that current serving members in positions of leadership should have particular responsibility for recognising the signs of mental health issues and monitoring the health and wellbeing of those in their care. We suggest that including a requirement for those in ADF positions of people leadership to recognise and respond, will help to address the cultural deficits identified by the Royal Commission and help to reduce stigma.

It would be beneficial to commit to further developing and promoting resources to help families to identify when their loved one may be struggling with their mental health. Currently, the objectives appear to focus predominately on the individuals in the workplace, whereas families may identify a change in wellness before anyone else and will often be instrumental in supporting a person to return to wellness. Further, the Strategy needs to consistently state "veterans, current serving members, and their families" when referring to programs that build help-seeking behaviour, reducing stigma, or training in mental health first aid.

The Strategy provides an opportune mechanism to introduce "family-readiness" or "family-focused" materials in prevention programs (e.g., tip sheets for spouses, targeted phone lines for family inquiries, explicit training for family members on mental health red flags).

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[15] Above n.2, [11].

[16] Above n.5 [101]-[123]

It would also be valuable to ensure that frontline medical staff receive additional resources and training to effectively support members presenting with mental health issues. It is important to recognise the real stigma surrounding mental health, as well as the significant concern regarding the potential for medical discharge. The focus should not be on clinically upskilling staff to provide mental health care but rather on equipping them to understand and address the broader impacts mental health has on individuals within the context of their service.

Call to Action

For Goal 2 of the Strategy to include specific reference to the role of families in prevention and early identification and an additional intention for ADF members in people leadership positions to be responsible for recognising and responding to signs that a member may be experiencing mental health and wellbeing issues.

Further, we call for resourcing specifically to support frontline medical staff to adopt a veteran-aware approach when patients present with mental health issues.

One of the wellness factors identified in the Strategy is 'home and housing', yet the Strategy itself does not specifically identify any objectives or actions to mitigate homeless as a risk factor for poor mental health. As with healthcare, housing sits within state & territory jurisdictions, predicating the need for a national strategy, or a national action plan.

Veteran-specific housing will often provide wrap around services to ensure long-term wellbeing outcomes for clients and to support their transition out of veteran or transitional housing into the private rental market. To be truly effective, this must be supported through a national coordinated approach to promote holistic, best practice service delivery.

A further complication is the veteran transition to ageing and the capacity of the aged care sector to care for the current and emerging cohort of older veterans. We are aware anecdotally that some veterans are considered too challenging for aged care providers, and they are at risk of being overlooked in favour of "easier" older people. The current aged care workforce is ill-equipped to meet the care needs of veterans with significant physical and mental health conditions. The Strategy fails to acknowledge the barriers facing this cohort of older veterans. Additionally, the strategy fails to address the growing cohort of widows of veterans facing homelessness following the death of their veteran spouse. Many of these have been long-term carers of their veteran spouses who have dealt with the impact of the trauma experienced by their spouse during their service.

Call to Action

We urge the Strategy to include actions to address veteran homelessness including access to aged care, specifically supporting people at risk of homelessness as an early intervention to mitigate the risk of poor mental health outcomes.

The Royal Commission noted with concern the evidence provided about the prevalence of sexual trauma among serving and ex-serving members of the ADF (Final Report, *Volume 3*: *Military Sexual Violence*). The report identified that the suicide rate for ex-serving women who served in the permanent forces and separated involuntarily for the reason 'retention-not-in-service-interest' is more than three times the rate of Australian females (245%

higher). [17] Further, the Commission noted that female reservists who separated from Defence in their initial training were 3.25 or 225% more likely to suicide than general population[18]. This cohort of women do not have non-liability health care (NLHC), while full-time female or male permanent reservists have NLHC after one day of service. As an aside, we note the definition of 'Reservists' used by the Royal Commission - *As distinct from the permanent forces, the reserves are a supplementary workforce that can be mobilised when the ADF needs additional personnel* is not reflective of the vital role they play in the Defence Force, which in turn fails to acknowledge the stresses and trauma that can be experienced by reservists during training and service. These critical issues must be addressed specifically in the Strategy.

The Commission made 47 recommendations in relation to its findings in Volume 3 – all of which were agreed to by the Government. This is an important issue which appears to have received no specific consideration in relation to the goals of the proposed Strategy.

In particular, the Commission recommended that the Australian Government should commission independent research into the prevalence of military sexual trauma among serving and ex-serving ADF members.[19] We note with concern, that there is already extensive research on military sexual trauma (MST). Continuously revisiting this issue without meaningful action risks re-traumatising survivors without delivering progress. Previous reviews, such as Broderick's, have made similar recommendations, and the ADF has had ample time to implement them. Rather, we advocate that independent research should prioritise addressing the persistent lack of accountability and transparency in handling complaints.

Call to Action

We ask that the Strategy include actions to implement relevant recommendations in Volume 3 of the Royal Commission into Defence and Veteran Suicide including through commissioning of independent research that is designed and conducted with a gendered perspective to identify gaps in services for all veterans and address the persistent lack of accountability and transparency in complaints management. This approach will ensure that any actionable outcomes lead to improved service delivery for everyone who has served and avoid grouping all women and families together as one distinct group with homogenous needs.

The Strategy to must also recognise the importance of supporting members through their transition period, particularly medical transitions.

We note Royal Commission Recommendation 75: *Conduct an independent review of Open Arms and publish the report*. The Government has agreed to this recommendation and acknowledges Open Arms' commitment to ongoing service improvement, and compliance with clinical standards and governance in their current work.[20]:

[17] Above n.1, [266].
[18] Above n.1, [236].
[19] Above n.1, [104].
[20] Commonwealth of Australia, *Australian Government Response to the Royal Commission into Defence and Veteran Suicide* (Response Paper, 02 December 2024) [97].

The Royal Commission stated - *This means there is limited ability to identify trends, assess the effectiveness of interventions, or compare results across different demographics or time periods. This inability to assess Open Arms services was identified by the Productivity Commission in its 2019 report A Better Way to Support Veterans.* [21] *DVA told us that it 'agrees that there is a need to improve its collection, analysis and reporting of Open Arms data'. It said Open Arms was 'taking steps' to 'evaluate and implement lessons learned through the collection and analysis of data' and noted it had begun work to develop a new case management system.*

Our proposal for DVA to develop a more sophisticated monitoring and evaluation capacity could help with gathering this information (see Chapter 18, Health care for ex-serving members). Doing so would better inform DVA decisions around the services that Open Arms provides and how they are delivered.

The 2023-24 DVA Annual Report included that Open Arms provided 337,477 services to 42,445 veterans and their family members. This demonstrates that Open Arms is a well-used service by veterans and their families. De-identified data regarding the issues being raised would be invaluable in identifying and seeking ways to address the mental health factors which are prompting veterans and their families to seek assistance.

Call to Action

We call on the Government to review Open Arms in accordance with recommendation 75 of the Royal Commission – with particular focus on developing a case management system which provides for *'a more sophisticated monitoring and evaluation capacity could help with gathering this information.'*

We urge the Government to include data gained from Open Arms experience into the Strategy.

Goal 3: Facilitate timely access to quality care and support

'The Defence and veteran community has stressed the importance of timely access to treatment and support where they are needed. Research also shows that timely access to care prevents the deterioration of mental health issues.'[22]

Goal 3 of the Strategy does refer to the Royal Commission's finding with regard to veterans' access to treatment and support. It should further identify that the Government has agreed to deliver on tools to improve access to the timeliness and quality of mental health screening. This would align directly with Goal 3 and allow an evaluation of the timeliness in delivering quality care and support via an action plan.

The RSL has conducted its own survey in relation to its members' access to health care. Of the 1,233 respondents, 24% advised of incidents when providers had refused to accept their

[21] Above n.1, vol 4, [294].
[22] Above n.2 [11].

Gold or White Card for payment. When asked the type of medical services that had been refused, there were 258 responses identifying difficulty in accessing GPs, Psychologists, Psychiatrists and Allied Health providers. DVA is aware of the barriers that veterans are experiencing in accessing health care and we strongly believe that Goal 3 can only be met if these issues are remedied.

The Australian Government has agreed to recommendation 65: '*that Defence will use data effectively to improve access to, timeliness and quality of mental health screening. The Government will commit to improving mental health screening. Defence will build on the work underway including mental health research underway and efforts to improve health assessments.* [23]

Call to Action

We call on the Government to recognise Recommendation 65 by the Royal Commission as a deliverable under the proposed Strategy.

To achieve this goal, the Government must commit to remedy the inequities in the medical system which is causing the medical providers to remove themselves from the long-established, and formerly very successful, DVA Card system, this includes a comprehensive review and uplift of renumeration to healthcare providers.

Whilst the Government has 'noted' – but not agreed with recommendation 71 of the Royal Commission, the difficulty that veterans and dependants have in accessing medical services should be noted and there should be a goal to improve this situation.

Beyond general barriers to health care, the Strategy fails to acknowledge the additional pressure of living in a rural or regional area where access to medical and allied health services can be scarce. The DVA rules have recently expanded to allow clinical psychologists to diagnose some mental health conditions as part of an initial liability claim – while this is an important and necessary improvement, there are still limitations which must be addressed in order to achieve Goal 3. For example, Nurse Practitioners can diagnose and medically treat mental health conditions and could improve access for veterans if they were also enabled to provide initial diagnoses for liability claims.

[23] Above n.9 [87].

Further, the Strategy should highlight the need for educating medical and allied health providers on delivering veteran-aware care. There is a broadly accepted knowledge gap in understanding and meeting veteran health care needs, which is further compounded for women veterans, who are often dismissed, especially by professionals from countries where women have not traditionally served in the military, due to a lack of understanding in the medical and broader community about the role of women in the ADF. Similar challenges exist for family members with DVA Health Cards.

Call to Action

We call on the Strategy to acknowledge barriers to accessing medical and allied health services in regional and rural areas. It must include specific, evidence-based actions to overcome these challenges, such as better utilisation of Nurse Practitioners.

Additionally, the Strategy must recognise the limited availability of services for women, particularly those who have experienced MST, as many may not seek care if they cannot access a female health professional.

The Strategy must aim to improve veteran-aware care, specifically identifying women veteran care as an at-risk cohort to ensure women veterans receive informed, equitable, and appropriate care, and acknowledge that there are family members with DVA Gold Cards.

Goal 4: Grow a positive and connected Defence and veteran community

The RSL notes and supports the factors that have been identified within Goal 4. Whilst it does state – '*strengthen connections among Defence, DVA, other government departments, ex-service organisations and community organisations to improve wellbeing outcomes*', it fails to note the important role that ex-service organisations (ESOs) play in the ongoing wellbeing of veterans and their families.

The goal does not refer to the work already being undertaken by DVA to improve its interaction with ESOs, nor does it commit to further consultation with ESOs to ensure they are working co-operatively with Government in the delivery of health services and the changes that will be involved in the implementation of the new legislation.

Future collaboration and engagement should not reduce the independence of the ESO sector or the ability of the sector and veteran community to collaborate with Government as an independent and equal partner.

Additionally, “connectedness” includes robust family networks, spouse/partner groups, children’s support programs, and family social events—ensuring families are not just secondary beneficiaries but integral parts of each community initiative. The Strategy could explicitly encourage tactive outreach to families in any national or local events, seminars, or supportive communities (e.g., local RSLs and Legatee networks).

Call to Action

We call on the Government to continue to review and improve its consultation with ESOs through the various forums and working groups.

Whilst the Government has agreed-in principle with Royal Commission recommendation 89 (*Establish a national peak body for ex-service organisations*), the Strategy should more clearly recognise and support the role of engaged and well informed ESOs in growing a positive and connected Defence and veteran community, particularly ESOs that have traditionally been excluded from the conversation such as *Women Veterans Australia*.

Goal 5: Prioritise suicide prevention initiatives

This Goal has identified the importance of de-stigmatizing suicidal distress and strengthening baseline wellbeing. The factors within the goal are excellent, but the document gives no indication as to how any of them will be achieved. As noted above, the importance of an action plan, or plans, and the ability to monitor and evaluate progress against the objectives is critical to success.

Noting that the National Suicide Prevention Office has released the *National Suicide Prevention Strategy 2025-35,* there is an opportunity to draw on some of the actions contained within that strategy, to inform an action plan to support this goal. It is positive that this has been acknowledged in the draft Strategy.

The Royal Commission provides invaluable guidance in this regard for example, the Royal Commission found that Defence risk management did not include risk factors for suicide and suicidality as part of organisational risk management or reporting[24] and recommended that Defence should *Address risk factors for suicide and suicidality and report on progress as part of enterprise-level risk management* (Recommendation 39). We note that the Strategy includes a short explanation of governance and accountability for the Strategy itself but this does not meet the intention of Recommendation 39.

Further, we consider it would be appropriate for the Strategy to include a mechanism to monitor and continually report on progress toward decreasing suicide rates amongst military personnel.

Given the research and statistics on the gendered nature of suicide and suicidality, it is crucial that this issue is examined through a gendered lens. Risk factors must be identified

[24] Above n.1, [119].

and reported accordingly to ensure targeted, effective interventions that address the unique experiences of men and women.

While the Strategy purports to address Defence members and families, and veterans and families, this goal heavily leans toward the needs of the Department of Defence and provides little contribution from the Department of Veterans' Affairs. The strategy could include the development of training and resources specifically for families (e.g., "Families as Gatekeepers" or "Family Peer Support Groups").

While suicide prevention is clearly the desired outcome, the strategy needs to address postvention and support for grieving family members, including along with the spouse and children, parents, siblings, and extended family members. There has been an example where a sibling of a veteran has suicided following the suicide of his brother.

Call to Action

We strongly advocate that Defence and DVA to conspicuously incorporate risk factors for suicide and suicidality into the strategy and report on progress as part of enterprise-level risk management. This should occur through a gendered lens to ensure the unique experiences of men and women can be considered.

The Strategy must also include specific mechanisms to monitor and publicly report on suicide rates.

Goal 6: Use evidence and data to drive positive outcomes

High quality evidence abounds in relation to the benefits of addressing many of the heightened risk factors when considering mental health issues. DVA's own research would lead them to links such as -

The link between

- chronic pain and mental health
- economic uncertainty and mental health
- physical fitness/activity and mental health
- In aged care – social isolation and mental health

DVA has the legislative and administrative tools to be able to deliver assistance in relation to these common issues which can have adverse effects on the mental health and wellbeing of veterans and their families.

Historically, DVA has shown limited interest in leveraging international research, even from within the Five Eyes community. By assessing their relevance to the Australian veteran context, we can adopt evidence-based approaches that enhance support and outcomes for all veterans.

The Strategy does not mention data collection relevant to families, leaving a gap in understanding how mental health and wellbeing issues extend to and affect spouses, partners, and children. It should include "family-related data points" when describing the types of data Defence and DVA should collect (e.g., usage rates of family counselling, spouse satisfaction with transitional support, child outcomes), and ensure that any evaluations or data "dashboards" collect, track, and report on the experiences of families independently (not solely as an add-on to veteran data).

Call to Action

We call on the Government to acknowledge existing, well publicised data, reporting and strategies which can make demonstrable improvements to the mental health and wellbeing of veterans.

The Strategy can also draw on existing international research and mitigation strategies that may be applicable to an Australian context while also promoting greater international research collaboration.

We urge DVA to use this evidence and data to inform policy and programming interventions that are developed to specifically address the goals of the Strategy.

Monitoring and Evaluation

This section of the Strategy states, *Consistent with the Royal Commission Final Report recommendation 38, we have prioritised the development of the monitoring and evaluation framework for this strategy, guided by the Commonwealth Evaluation Policy and supporting Toolkit.*

While the previous strategy *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023* included a detailed section on governance and on monitoring, it is noted that the current strategy refers to individual monitoring and evaluation frameworks aligned with each new initiative implemented under the Strategy. We advocate that these frameworks are developed and included as part of the Strategy, including a mechanism to ensure public accountability and transparency against not only the Strategy but also as it supports the implementation of the Royal Commission recommendations.

It is clear that developing a framework for monitoring data was a clear focus of the previous Strategy (2020-2023). It goes on to state -

'*Over the course of the next four years, DVA will work to set a baseline of outcome measures and continue to collaborate across government, particularly with Defence and the NMHC, and the research community to monitor, evaluate and measure the mental health and wellbeing outcomes of veterans and their families, the effectiveness of this Strategy and National Action Plan, and effective system performance. Where possible, DVA will align the baseline outcome measures with the measurable national key performance indicators outlined in the Fifth Plan*'

A key finding of the Royal Commission was the difficulties for Defence and DVA to provide accurate and current data about defence and veteran mental health and wellbeing. When reading the paragraph regarding Monitoring for Success in the 2020-2023 Strategy, it could be taken that DVA would now have monitoring systems in place which would be able to effectively report on and evaluate the various pilots, programs and initiatives that were undertaken.

Call to Action

We call on the Government to identify the progress that has been made during the previous four years towards establishing a monitoring and evaluation framework. Rather than committing to building new monitoring and evaluation frameworks, they should be looking at expanding the existing frameworks – with clear reporting requirements. Simply re-writing the same words into each Strategy, with no evidence of progress is not satisfactory.

Concluding remarks

Collectively, we share concern that the proposed *Defence and Veteran Mental Health and Wellbeing Strategy 2024-2029* has not sufficiently recognised the value of the evidence and recommendations provided by the *Royal Commission into Defence and Veteran Suicide* and note that many of the goals identified in the Strategy would benefit by referring to the Royal Commission.

The Government has agreed to 104 of the Recommendations made by the Royal Commission. This Strategy should be the tool to clearly identify that the Government is committed to delivery on the agreed recommendations and include a robust monitoring and evaluation framework to enable transparent reporting against implementation.

We also note the lack of discussion around gender and diversity within the veteran community, a critical oversight that risks reinforcing the outdated stereotype of a typical veteran. This, in turn, marginalises women and other minority groups. It is essential to recognise that while men and women serve alongside each other, their experiences of service can differ significantly, often leading to variations in how symptoms manifest and the effectiveness of treatment interventions. A more inclusive approach is necessary to ensure equitable support for all veterans.

We strongly suggest that this strategy links to other Governmental documents such as the Australian Government Gender Equality Strategy and the DVA women's strategy which is currently underway.

We strongly suggest that a supporting National Action Plan, or goal-specific action plans, be developed to inform delivery against the Strategy, and also mapped to the recommendations of the Royal Commission. The development of the National Action Plan should be undertaken in consultation with the Defence and veteran community.

We note the Royal Commission Recommendation 122 – *Establish a new statutory entity to oversee system reform across the whole Defence Ecosystem*. We are concerned that the body as proposed in Schedule 9 of the *Veterans' Entitlements, Treatment and Support (Simplification and Harmonisation) Act 2024* (the VETS Act) will require further review for it to be able to successfully oversee a system of reform across the whole Defence ecosystem which includes the implementation of the Strategy.

We note the closing paragraphs of the proposed Strategy –

> *'We recognise the importance of keeping the Defence and veteran community informed about our work on mental health and wellbeing. This strategy and its actions plans will be publicly available through the Defence and DVA websites.*
>
> *Defence and DVA are accountable to the Australian Government, the Australian public, and the Defence and veteran community. Each department will report on progress against this strategy and its action plans through the departmental annual reports.'*

The above paragraph refers to action plans being publicly available – whilst the veteran community welcomes the Government's commitment to transparency and accountability, we again note that the Strategy appears to make no provision for an Action Plan and again, we highlight the importance of having such a plan incorporated into the Strategy.

Further, we are concerned that reporting through the relevant annual reports will not provide sufficient detail on the progress being made to deliver on Mental Health and Wellbeing issues, including outcomes for families (mental health usage data, housing/homelessness data, family satisfaction surveys), and we ask the Government to include additional reporting measures. We suggest that an annual report on this should be tabled in Parliament as part of the ongoing response to the Royal Commission recommendations. Additionally, specific areas within the strategy should be assigned to individual positions, rather than entire departments, to ensure accountability and transparency, both of which are essential for driving cultural change.

The inclusion of APS workforce as being part of the Defence and veteran mental health and wellbeing strategy is a welcome step forward in recognising the blended nature of Defence. As recognised in the strategy, some veterans choose to return to Defence as an APS member. However, there is little guidance on supporting APS to access the services briefly mentioned in the strategy. While this may be a more tactical consideration, it would be helpful to understand where in the strategy such a need is being recognised and how this will be incorporate as part of reporting, beyond including a diagram and some paragraphs.

We also recommend a review of the imagery included in the document, more diverse service imagery should be utilised that shows men and women working alongside each other in uniform. Imagery reinforcing stereotypes should be avoided.

We reaffirm that any reform efforts must consider both veterans and their families as integral stakeholders from development to evaluation. By integrating families more explicitly in each of the six goals and in any accompanying action plans, the document will more comprehensively address how mental health, wellbeing, and suicide prevention efforts extend beyond the individual service member. Consistent references—rather than occasional—help ensure that policies and programs reflect the lived reality of veterans' and serving members' households and drive stronger outcomes for the whole Defence and veteran community.