Australian Government

Department of Veterans' Affairs

Department of Defence

The ADF Service Women Steering Committee

Report to Commissions 2013

Table of Contents

Australian Government
Department of Veterans' Affairs
Department of Defence

Repatriation Commission
Military Rehabilitation and Compensation Commission
GPO Box 9998
Canberra ACT 2601

Dear Commissioners

As co-chairs of the Australian Defence Force (ADF) Service Women Steering Committee (the Committee), we are pleased to present this report to you. The report is the culmination of the work of the Committee, who met six times between May and August 2013 to consider the needs of current and former serving female Members of the ADF.

The Committee considered Dr Samantha Crompvoet's research report *The health and wellbeing of female Vietnam and contemporary veterans* as a starting point for discussion. Members were open in sharing their experiences of serving in the ADF and accessing services provided by the Department of Defence and the Department of Veterans' Affairs (DVA). The Committee was also briefed by a number of Defence and DVA business areas. The Committee has considered a broad range of concerns to current and former serving female Members. Those considerations have led to a series of recommendations to the Commissions for consideration.

We thank the Members of the Committee, for their Service and their contribution to the work of the Committee.

We recommend this report to you.

Sincerely

G.M. Anderson

Gayle Anderson
Assistant Secretary
Client Strategy and
Defence Relations Branch
Department of Veterans' Affairs
14 November 2013

Fogarty

Major General Gerard Fogarty AO
Head, People Capability
Department of Defence
14 November 2013

Executive Summary

This report presents the findings of the Australian Defence Force (ADF) Service Women Steering Committee that was convened between May and August 2013.

Following consideration of the research report *The health and wellbeing of female Vietnam and contemporary veterans* by Dr Samantha Crompvoets, the Repatriation and Military Rehabilitation and Compensation Commissions (the Commissions) directed the establishment of the ADF Service Women Steering Committee (the Committee). The Committee was to further consider the needs of current and former serving female Members and make recommendations to ensure policies, practices and programs across Defence and DVA are responsive the needs of ADF servicewomen, female veterans and their families. The Committee was jointly chaired by the Department of Veterans' Affairs (DVA) and the Department of Defence (Defence). Membership included broad representation from current and former ADF Members.

The Committee considered a range of issues across topics including health care, mental health, rehabilitation, family support and transition. The Committee found the Support Continuum a useful framework to consider issues. The Support Continuum describes seven key process that support Members across Defence and DVA:

1. Prevention;
2. Health Care and Recovery;
3. Liability Determination;
4. Member Support;
5. Return to Work;
6. Transition; and
7. Post Transition Care and Support.

The Committee concluded that there are no major gaps in Defence or DVA services evident for current and former serving female Members. However, a lack of awareness of the availability of services and other barriers to accessing available services were a significant concern. A number of Committee Members were not aware of the range of services available to them and their families, or how they could access these services. In the Committee's view that there are significant barriers to accessing existing services[1], is consistent with the findings of Dr Crompvoets.

A focus of the Committee's discussion was consideration of options for Defence and DVA to address barriers to access with the target of increased usage of the services available.

The Committee has made 24 recommendations for consideration by the Commissions. Six recommendations are specific to Defence; eleven are specific to DVA; and seven are relevant for both Defence and DVA. These recommendations align with summary recommendations[2] within *The health and wellbeing of female Vietnam and contemporary veterans*.

[1] *The health and wellbeing of female Vietnam and contemporary veterans*, p.20
[2] These recommendations are provided at Attachment C.

Summary of Recommendations

1. Defence and DVA consider a common access portal for information about services available for all current and former serving Members.

2. Defence consider broader dissemination of information about women's health and coping strategies.

3. DVA review and refresh its internet page on women's health, with greater acknowledgement of the role and contribution of female serving Members.

4. That the impacts of service in the ADF on fertility be considered as a topic for focused research through Defence and/or DVA research programs.

5. Defence and DVA review the trigger points for referral/entry into their respective rehabilitation programs with a view to increasing female participation rates.

6. A gender lens should be applied to all Defence and DVA information products.

7. DVA, through its Commissions, make a request to the RMA to investigate whether SoPs can be determined for female sexual dysfunction.

8. That DVA consider arrangements to enable female clients to speak with female DVA staff members, when requested.

9. That DVA encourages ESOs to recruit female advocates.

10. That DVA consider directly requesting female veteran nominations from ESOs to be part of the National Consultative Framework.

11. Diversity publications to be made more accessible for all ADF Members.

12. Defence and DVA consider integrating information from Defence Community Organisation (DCO) and the Veterans and Veterans Counselling Service (VVCS) to identify 'hotspots' enabling more targeted prevention initiatives.

13. DVA investigate whether or not the On Base Advisory Service (OBAS) can report the gender breakdown of ADF Members accessing the service.

14. VVCS review its Crisis Assistance Program (CAP) to ensure it meets the needs of contemporary veterans and their families.

15. Consideration be given to the development of graduated and flexible post-partum return to fitness programs that are responsive to the circumstances of individual Members.

16. Consideration be given to increasing the awareness of Physical Training Instructors (PTIs) of post partum health and fitness issues.

17. Consideration be given to a point of contact being developed in the ADF to assist females meet their Defence-specific occupational requirements particularly in the post natal period.

18. Defence consider whether Members whose separation from the ADF is related to a traumatic incident (i.e. where a person has been a victim of sexual assault), should be automatically eligible for assistance through Career Transition Assistance Scheme (CTAS).

19. Defence and DVA review information about services for Reservists, and how that information is provided, to ensure Reservists are fully aware of the services and supports available to them.

20. DVA undertake an active campaign to make female veterans aware of DVA services.

21. The location of childcare options to be taken into consideration for the location of all future VAN/VVCS offices.

22. DVA develop resources to assist veterans to develop their own support groups in their local area with DVA to maintain details of groups available on its website.

23. VVCS review demographic data by location to identify areas of higher female veteran usage with a view to holding female-only veteran group programs.

24. The Defence Links Steering Committee (DLSC) investigate the possibility of Support Continuum performance reporting by gender (where relevant) to ensure Support Continuum processes are meeting the needs of the female cohort.

Introduction

> The Department (of Veterans' Affairs) has historically provided most services and programs for male veterans. We need to ensure equity in access across all services available for all those who are entitled to services and support.
>
> *DVA Veteran Mental Health Strategy 2013 - 2023*

Female Members are the fastest growing cohort in the ADF.[3] As at 1 October 2013, women make up 18.3 per cent of Royal Australian Navy (Navy) personnel, 11.2 per cent of the Australian Army (Army) and 17.7 per cent in the Royal Australian Air Force (Air Force), at an average of 14.5 per cent of the ADF permanent workforce. These figures have risen over four per cent since 2010 and numbers of servicewomen are predicted to rise. In early 2013, the Chiefs of Service Committee agreed that the target female ADF participation rate to be achieved by 2023 is 25 per cent for Navy and Air Force and 15 per cent for Army. Recruitment campaigns targeted at women, and the implementation of more flexible work arrangements to aid personnel retention, are examples of strategies to achieve these targets.

The increasing number of serving women has had a flow on effect to DVA. Since 2010, female veteran client numbers have increased steadily – approximately 0.2 per cent each year. As at 28 June 2013, it is estimated that 7.6 per cent of veterans with one or more accepted conditions under any Act[4] were female. This equates to 11,247 females from a total 147,789 veteran clients. For those under the age of 25, the proportion is 23.1 per cent, or 315 females from 1,362 total veteran clients.

Through the Applied Research Program, DVA funded Dr Samantha Crompvoets to undertake research to better understand the experiences of females serving in the ADF, and the long term impact of their service on their health. Dr Crompvoets' three year study (2009 – 2012) examined female Vietnam and contemporary female veteran health and wellbeing, using in-depth interviews with 60 female veterans and 30 professional stakeholders, as well as literature reviews of research, mainly from the United Kingdom and the United States.

Key findings by Dr Crompvoets in her report of the study *The health and wellbeing of female Vietnam and contemporary veterans* include that:

- overall, female veterans framed their military career experiences mostly positively;
- women felt they were both empowered by their military career and achievements, but at the same time disempowered through a lack of appropriate resources and support following discharge;
- they reported many mental, physical and reproductive health and wellbeing issues that they attributed to their service;
- common challenges attributed to service included maternal separation and motherhood issues, belonging to a minority group, sexual harassment and abuse and readjustment to life after the military;

[3] The *Review into the Treatment of Women in the ADF Phase 2 Report* by Sex Discrimination Commissioner, Elizabeth Broderick, highlighted the need for increased participation rates of women in the ADF. The implementation of this Report is part of the Department of Defence's broader *Pathway to Change* Framework.

[4] These Acts are:
Veterans Entitlements Act 1986 (VEA)
Safety, Rehabilitation and Compensation Act 1988 (SRCA)
Military Rehabilitation and Compensation Act 2004 (MRCA)

- there was a perceived lack of appropriate support from DVA and limited services to address their specific needs as female veterans; and
- women's identity as 'veterans' was lacking or ambiguous.

Other issues raised by Dr Crompvoets in her report include:

- the importance of acknowledging and addressing female veteran specific issues – reproductive and gynaecological health, domestic violence, sexual harassment and abuse/assault;
- a lack of authentic 'veteran' identity for female veterans reinforced by attitudes/limited understanding of their issues (as mothers, as women, as victims of harassment/violence) by DVA staff and community health providers;
- a lack of trust in the confidentiality of DVA/ADF services;
- a stigma associated with mental health issues and seeking help;
- a lack of trust in DVA's system of claims processing, particularly in relation to staff understanding of impacts of sexual harassment, abuse and violence;
- a gap between treatment/compensation information given at time of discharge and when that information is actually needed;
- a perceived/experienced lack of understanding of gender issues in relation to transitions (e.g. maternal separation and parenting);
- a lack of support services provided through DVA arrangements targeted at female veterans; and
- a lack of resources to facilitate continuity of learned coping strategies.

The health and wellbeing of female Vietnam and contemporary veterans was the first in depth study of Australian female veterans. The study was undertaken across a three year period from 2009 to 2012. Significant changes have occurred within Defence and DVA services during, and since the study that have enhanced care and support for contemporary veterans, including female veterans, and their families. The Committee has noted these developments within this report. A full list of reference documents, guest speakers and other sources of information the Committee took into account is at Appendix B.

Dr Crompvoets' report and a discussion paper by Health and Community Services Division (CM6803 / MRCC161/2012) was considered by the Repatriation and Military Rehabilitation and Compensation Commissions (the Commissions) on 2 November 2012. The Commissions noted the discussion paper and subsequently requested that the Client and Commemorations Division establish a steering committee in conjunction with the Department of Defence which is to include current serving women to examine what general services and specific services are necessary to support ADF service women.[5]

A Committee was formed consisting of representation from:

- current serving and former ADF Members;
- Navy, Army and Air Force;
- Army and Navy Reserves;
- Commissioned and Non Commissioned Officers;
- Members who have deployed (Somalia, East Timor, Iraq, and Lebanon, Syria, and Afghanistan);

[5] Meeting of the Repatriation Commission - Decision 2 November 2012

- dual serving couples and families; and
- Defence Families Australia (DFA).

Committee Members' biographies are at Appendix A.

The Committee's Terms of Reference is to:

1. Identify key issues relating to the provision of Defence and DVA services for current serving and former ADF servicewomen from the point of transition onward, emerging from:
    a. the research report – *The health and wellbeing of female Vietnam and contemporary veterans*;
    b. the knowledge and experience of Steering Committee Members;
    c. discussions with relevant Defence and DVA decision makers, who will be invited to relevant meetings; and
    d. other relevant material considered by the Steering Committee.
2. Examine Defence and DVA services provided for current and former ADF Members.
3. Identify gaps in Defence and DVA service delivery for current and former ADF Members, their families or supports, including any barriers in accessing existing services.
4. Develop options to address Defence and DVA service delivery gaps and/or accessibility issues.
5. Provide a report to the Commission detailing the work of the Committee including recommendations for improving Defence and DVA services for current and former ADF Members (being gender-specific as appropriate) from the point of transition onward.

Committee Members felt that some issues, for example those relating to mental health or rehabilitation, were so important not only to the female veteran experience that they required consideration by the Committee. As a result, some recommendations have broader application than the female cohort only.

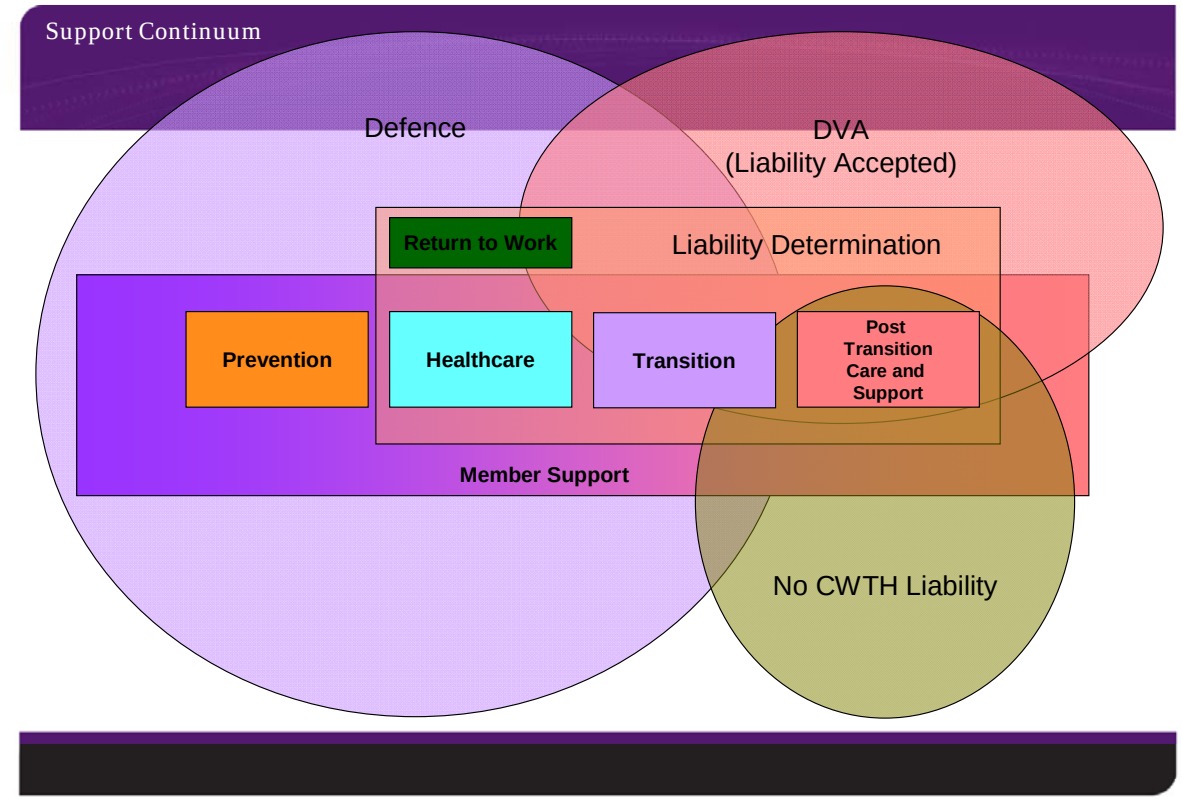
The Support Continuum

Through the Support for Wounded, Injured or Ill Program (SWIIP), Defence and DVA have been working closely together to establish a 'whole of life' approach to the care of wounded, injured or ill ADF Members. In 2010, Defence conducted a review of the system of support for caring for wounded, injured or ill personnel. A key outcome of the review was the development of the Support Continuum. This is a coordinated and integrated system of support for wounded, injured or ill ADF Members that extends across Defence and DVA and is divided into seven key processes:

1. Prevention;
2. Health Care and Recovery;
3. Liability Determination;
4. Member Support;
5. Return to Work;
6. Transition; and
7. Post Transition Care and Support.

The Support Continuum is represented by the following diagram.

Figure 1: The DVA and Defence Support Continuum.



The Committee found the Support Continuum a useful framework with which to consider issues relating to female veterans. This report discusses issues and makes recommendations against each of the seven key Support Continuum processes.

1. Prevention

> A robust and agile ADF relies on every Member having the opportunity to contribute fully and equally to Defence operations and capability.
>
> General D.J. Hurley, AC, DSC
> Chief of the Defence Force, 2012

Prevention reflects those activities within Defence that are aimed at establishing an environment where people work together to improve capability by preventing injury and illness and effectively managing the impact on people, reputation, recruitment and retention should an injury or illness occur.

This has an important flow on effect for those who may need to approach DVA for assistance as a result of their service. For those who have already transitioned into the civilian environment, DVA should be seen as a point of contact for prevention strategies in relation to veteran and family mental, physical and social health.

The Committee considered that the provision of information is an important component of the prevention process noting that women are more likely than men to use self-management strategies and to seek out information to address health needs.[6]

The Committee considered the range of service offerings by Defence and DVA, detailed at Table 1.

Table 1: Defence / DVA service offerings considered by the Committee

Defence	DVA
• Department of Defence website & intranet • Army website & intranet • Air Force website & intranet • Navy website & intranet • Joint Health Command (JHC) website • JHC all hours helpline 1800 IM SICK (1800 467 425) • Garrison Health Operations • Defence Community Organisation website • Defence Family Helpline (1800 624 608) • Information handbooks (produced by the Services as well as JHC) • Defence Families Australia website • Sexual Misconduct, Prevention and Response Office (SeMPRO) 24/7 support service (1800 SEMPRO, also includes text (sms) and email options)	• DVA website • DVA At Ease mental health web portal • Veterans' Access Network and General Enquiries Line • DVA On Base Advisory Service • Veterans and Veterans Families Counselling Service website and all hours counselling service

It was acknowledged by the Committee that people may also source information directly from other community sources, such as Beyond Blue, Relationships Australia or women's health services. Whilst important organisations, the services provided by these groups have not been considered in this report.

[6] *Gender differences in mental health among serving and ex-serving military personnel: A review of the literature*, p.5

Improving connections to available services

The Committee noted the broad range of prevention and information services available for both serving men and women across Defence and DVA. However, people must be able to connect with the right service at the right time for them and the Committee considers that a lack of knowledge about available services is a barrier to access, especially for servicewomen and Reservists. In fact, a number of Committee Members were not aware of the range of services available to them and their families, or how they could access these services.

A lack of knowledge about available services is also identified as an issue in Dr Crompvoets' report: overwhelmingly, women did not know what services were available to them regarding mental health support, or what they might need in the future.[7]

An absence of knowledge about services as a barrier to access is a recurring theme within this report.

These issues are amplified for Reservists, who may have eligibility to access some Defence services, but not all and who may not have access to the same information channels as other Members. Reservists are a unique client group facing different challenges to their regular/permanent peers relating to management of both a civilian and a military life, deployments, post operational assistance and support for their families. There is no 'one stop shop' for Reservists to receive advice on services and how they may be accessed.[8] Information and support for Reservists and their families needs to be made more clear.

Since 2006, DVA has undertaken a gradual rationalisation of the telephone numbers clients use to seek information or access to different services. The 133 254 general enquiries number is now a central intake number for most DVA enquiries (for regional callers the number is 1800 555 254). The major exception to this is the VVCS Veterans Line – the

24 hour crisis support and counselling service. To avoid duplication, Defence might consider analysing access arrangements for prevention and information services that are in place for ADF Members and their families. For example, a review of the range of all helpline/hotline telephone numbers.

Further, both Departments should consider a central access point where information on all Defence and DVA services is available – the Committee referred to this as a form of 'need help now button'. This particular access point would need to be well advertised, through Defence and DVA websites and information materials. Ultimately, such an approach would enable a current or former serving Member - Regular or Reserve - or their family, who needs help, to access information more easily through a common portal at the time it is required.

[7] *The health and wellbeing of female Vietnam and Contemporary Veterans*, p.25

[8] *Review of Post-Operational Support for Reserve Members*, p.3

Stigma of reporting illness as a barrier to care

> It is ADF policy that Members must be deployable to remain in the ADF…this in itself is a considerable barrier to seeking care in the ADF and an incentive to either conceal medical problems including mental health problems…
>
> Professor David Dunt, 2009.

The Committee discussed perceived stigma associated with reporting illness or injury and the resultant barrier to care. Dr Crompvoets' research identified this, particularly in relation to a deterioration in mental health for female veterans and noted a major implication in 'severely delayed treatment seeking, often until they are at crisis point'.[9]

In addition to the stigma, there is also a fear of possible medical downgrades (with associated deployment and employability issues) or a possible medical discharge. This could be alleviated through improved mental health literacy, helping ADF Members understand that people can and do recover from mental health problems – similar to many physical ailments.

Joint Health Command is driving a significant process of change to challenge cultural norms about reporting illness. One example is a priority action identified in the *ADF Mental Health and Wellbeing Strategy*, the development of a peer support network and initiatives to reduce mental health stigma and barriers to seeking care (p.28).

The Committee strongly supports the work being undertaken by Defence in this area.

Recommendation

1. Defence and DVA consider a common access portal for information about services available for all current and former serving Members.

[9] *The health and wellbeing of female Vietnam and Contemporary Veterans*, p.25

2. Health Care and Recovery

Health care and recovery involves the provision of acute care immediately after wounding or injury, or the relevant medical treatment following the diagnosis of an illness. It also includes the rehabilitation required to return a wounded, injured or ill Member to maximum effectiveness within the ADF environment or, if this is not possible, the civilian environment.

This phase of the Support Continuum is largely the domain of Defence, although if a claim is lodged and liability accepted, DVA becomes involved. The exception to this is treatment, which is available through DVA with a diagnosis of certain conditions, including mental health conditions where a claim for compensation need not be lodged to obtain treatment.

The Committee considered the range of service offerings by Defence and DVA, detailed at Table 2. These service offerings refer serving or former serving ADF Members or their families to appropriate supports, or can be direct channels for treatment, service delivery and/or support.

Table 2: Defence / DVA service offerings considered by the Committee

Defence	DVA
• JHC all hours helpline 1800 IM SICK (1800 467 425) • ADF All Hours Support Line (1800 628 036) • Defence Family Helpline (1800 624 608) • SeMPRO 24/7 support service (1800 SEMPRO, also includes sms and email options) • Army-SWIIP (A-SWIIP) • Member Support Coordinators • Soldier Recovery Centres • ADF Rehabilitation Program • Garrison Health Operations • Contracted health professionals who deliver services to Defence personnel through the Medibank Health Solutions contract	• DVA On Base Advisory Service • DVA website • DVA At Ease mental health web portal • DVA YouTube mental health videos • Post Traumatic Stress Disorder (PTSD) Coach Australia app • Veterans' Access Network and General Enquiries Line • DVA rehabilitation services • DVA health care services • DVA non-liability treatment health care for diagnosed conditions including PTSD, anxiety or depressive disorders • Veterans and Veterans Families Counselling Service website and all hours counseling service

Information / coping strategies for female personnel

The Committee is of the view that there is inadequate information on female health and related coping strategies within Defence, particularly in relation to gender-specific topics such as menopause and reproductive issues. Having this information more widely available may assist servicewomen to cope with women's health issues, which may be affecting or concerning them.

DVA has a page on its website dedicated to general women's health issues, although it is not specific to the female veteran experience.[10] It has not been updated for several years and would benefit from being reviewed.

[10] www.dva.gov.au/health_and_wellbeing/physical_health/women_health

Continuity of Defence health care

From data analysed about deployment experiences in the Middle East Area of Operations (MEAO) Census Study, there is little evidence of gender differences in general health measures, although women tended to report more medically diagnosed conditions (including sinus problems and migraines) following deployment than men.[11] Given the nature of Defence service, the Committee is concerned by the potential lack of continuity of care whilst serving because:

- of the nature of postings and appointments in Defence; and
- there is no surety that a serving Member will see the same doctor at subsequent visits and establish an enduring relationship as many civilians would when visiting their family general practitioner (GP).

As a result of these factors, health information availability is more important for ADF personnel because they do not have the opportunity to establish enduring patient/GP relationships like the general public. Serving Members therefore need to take greater ownership of their wellbeing, in which access to health information plays a key part.

A representative from JHC outlined Defence's healthcare arrangements, including the ADF Rehabilitation Program, Garrison Health Operations and the contract for health services provision through Medibank Health Solutions (MBHS). Committee discussion included past personal experiences of problems accessing health services while on leave. This discussion was useful to highlight that policies and processes for the delivery of health care in Defence have generally improved, especially in relation to maternity leave.

Some issues were noted in relation to the current MBHS contract that JHC is aware of and is working with service providers to develop a better understanding of ADF personnel, their unique occupational circumstances and how this relates to health care. A recommendation from the *Joint House Inquiry report into the Care of ADF Personnel Wounded and Injured on Operations*, recommended the Department of Defence:

> annually publish written assessments of garrison health care contractor key performance indicator statistics. The Committee further recommends that the written assessments include the results of an ongoing survey of Australian Defence Force personnel regarding their experiences with the performance of garrison health care contractors. (p.48)

The Committee agrees with this recommendation.

Fertility and the impacts of Service

The Committee were not aware of any Australian military research studies in existence that focus on the impacts of Service on fertility of either male of female ADF Members. Female veterans over 40 years of age who took part in Dr Crompvoets' study were concerned that reproductive health issues were attributable to Service[12] (including birth and labour complications, miscarriage and birth defects). This was not, however, found to be common with participants under 40 years of age in the study. There is little information available to understand if the incidence of fertility or reproductive issues are higher in serving women.

The MEAO Census Study recommended more detailed analysis to ascertain if deployment experiences have adverse effects on fertility, pregnancy outcomes or children's health.[13]

[11] *MEAO Census Study Summary Report*, p.45
[12] *The health and wellbeing of female Vietnam and contemporary female veterans*, p.21
[13] *MEAO Census Study Summary Report*, p.46

The Committee formed a view that fertility was an area that required future focused research that could be undertaken through Defence and/or DVA research programs.

Rehabilitation

The ADF and DVA both have formal rehabilitation programs in place. Rehabilitation programs can include any mix of the following care: medical; dental; psychiatric; in-patient and out-patient care; physical exercise and physiotherapy; psychosocial training and counselling; aids and appliances; and modifications to workplaces, homes and cars.

The ADF Rehabilitation Program (ADFRP) aims to:

- reduce the impact of injury or illness through early clinical intervention;
- reduce any psychological effects of the injury;
- return the Member to suitable work at the earliest possible time; and
- provide a professionally managed rehabilitation plan tailored to individual needs.[14]

DVA uses a tailored approach to meet the needs of the individual after discharge, that addresses social, psychological, vocational and educational factors to ensure that whole of person rehabilitation needs are addressed.

Considering the data available, female participation rates in the ADFRP are consistent with both VVCS and Army female participation rates (approximately 10 per cent), but these figures are much lower than the percentage of females who are medically separating (38 per cent). This highlights the possibility that not all servicewomen are given adequate opportunity to rehabilitate before being medically discharged.

The Committee also noted the top five primary health conditions presented by females across Defence and DVA, as outlined at Table 3. It is important to note that the DVA data is female veteran-specific and has not been included with the general female DVA client data (which would include a proportion of war widow clients).

Table 3: Top five female primary health conditions (as at August 2013)

	ADFRP referrals (female)	DVA accepted conditions (female veterans)
1	Psychological System	PTSD
2	Back – upper or lower	Depressive disorders
3	Knee	Acute sprain and acute strain
4	Lower leg	Tinnitus
5	Shoulder	Lumbar Spondylosis

In comparison for the DVA data, male veterans have similar accepted conditions, albeit in a slightly different order (1. PTSD, 2. Tinnitus, 3. Sensori-neural hearing loss, 4. Lumbar Spondylosis, 5. Acute sprain and acute strain). No major discrepancies were found by the Committee in relation to these statistics. However it was noted that after deployment, female veterans were more likely to have symptoms of mental health problems than men and were less likely to report feeling well-supported by the military.[15]

[14] Department of Defence Submission to the *Care of ADF Personnel Wounded and Injured on Operation Inquiry*, p31-32

[15] *MEAO Census Study Summary Report*, p.5

The Committee was impressed by the commitment to formal rehabilitation programs in both the ADF and DVA. Based on the discrepancy in the data for females medically separating, findings from the MEAO Census Study Summary Report and discussion of experiences, the Committee questioned whether these rehabilitation programs are identifying everyone they are intended for, and whether current trigger points for entry into rehabilitation programs would benefit from a review.

Mental Health

The 2010 ADF Prevalence and Wellbeing Study showed that 22 per cent of the total ADF population had experienced a mental disorder in the previous 12 months, similar to the general Australian community rate of 20.7 per cent and that ADF females are not significantly different from females in the Australian community, other than having a lower prevalence of alcohol disorders.[16]

Mental health care in DVA is provided to clients in receipt of pensions, allowances, and/or health care. The Committee learned that of the 46,500 veterans with an accepted mental health disability, about 28,500 have a stress related disorder, including PTSD. From post 1999 conflicts, there are 429 female veterans with one or more accepted mental health conditions (and 5,519 males). The new *DVA Veteran Mental Health Strategy* provides a ten year framework for the provision of mental health care in the veteran and ex-service community and for addressing mental health needs. It highlights the diverse needs of DVA clients including the mental health challenges that may be attributed to Service for women in the ADF.[17]

The Committee acknowledged the announcement of additional funding of $25.3 million for enhanced mental health programs in the May 2013 Federal Budget. The following initiatives that were of benefit to current and former ADF Servicewomen and their families were noted:

- The expansion of non-liability health cover to include access for former ADF Members with eligible peacetime service after 1994; and treatment for alcohol and substance misuse disorders.
- The post discharge GP Fitness Check; using a purpose built screening tool for former ADF Members.
- The expansion of VVCS eligibility to include border protection personnel, Australian and overseas disaster zone personnel, personnel involved in training accidents, ADF Members medically discharged, and submariners; Partners and dependent children up to the age of 26 of these groups; and Partners, dependent children up to the age of 26 and parents of ADF Members killed in service-related incidents.
- The enhanced pathways program to assist veterans with mental health problems access appropriate DVA arrangements.

Three implications highlighted in a recent Australian Centre for Posttraumatic Health literature review, commissioned by DVA, resonated with members of the Committee. The literature review focused on female veteran mental health and reported:

- Some women report that veteran services are more designed for men, and some women have difficulty identifying as a veteran. Resources developed for military and veteran populations should reflect women's mental health and related needs.

[16] *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study* Executive Report, p.6

[17] *DVA Veteran Mental Health Strategy*, p.13

For example psychoeducation, self-help programs and materials should include both images and content relevant to women.

- The status of women as veterans should be further acknowledged to enhance the perception that they are a part of the veteran community. Education for health providers, as well as for commemorative events and activities that highlight the experience and contributions of women in the ADF, may help to overcome the perception that women are not 'real' veterans.
- Primary care facilities are an important pathway for mental health care for many serving and ex-serving ADF Members. The promotion of gender-sensitive services at the primary care level both during and following military service may increase the likelihood of identifying and assisting women at risk of mental health problems.[18]

The Committee recommends that in order for Defence and DVA to address these concerns, a gender lens should be applied to all information products, including in the areas of health, commemorative activities and service delivery. The Committee viewed a range of brochures and concluded that a gender balanced approached has been considered in their design, but believes a strong, global directive is required for perceptions of inequity to shift.

Recommendations

2. Defence consider broader dissemination of information about women's health and coping strategies.

3. DVA review and refresh its internet page on women's health, with greater acknowledgement of the role and contribution of female serving Members.

4. That the impacts of service in the ADF on fertility be considered as a topic for focused research through Defence and/or DVA research programs.

5. Defence and DVA review the trigger points for referral/entry into their respective rehabilitation programs with a view to increasing female participation rates.

6. A gender lens should be applied to all Defence and DVA information products.

[18] *Gender differences in mental health among serving and ex-serving military personnel: A review of the literature*, p. 6-7.

3. Liability Determination

Liability determination encompasses those activities required for DVA to assess a claim and make a determination as to whether there is a liability on the Commonwealth and, if so, what that liability is in terms of support and compensation to be provided. For many current and former serving Members, this may be the first time they have contact with DVA.

DVA is the lead agency in this phase of the Support Continuum, though some assistance may be provided by Defence for a serving Member through Member Support Coordinators and ADF Rehabilitation Program Case Managers. Some clients may also choose to access assistance from an advocate through an Ex-Service Organisation.

The Committee noted that since 2009 (when Dr Crompvoets' study commenced), a number of programs and other initiatives have been implemented by DVA to improve service delivery and liability determination for all contemporary veterans, including female veterans. However, the Committee was concerned that self identification by current and former female serving Members as 'veterans' may be a barrier to making claims.

Table 4 outlines Defence and DVA services available in the liability determination phase, encompassing claims submission, determination and compensation. In the event of an unsuccessful claim, this stage may also include an appeals process.

Table 4: Defence / DVA service offerings considered by the Committee

Defence	DVA

• Member Support Coordinators (implemented through SWIIP)
• ADF Rehabilitation Program (Case Manager)
	• On Base Advisory Service
	• DVA website
	  ▪ Benefits Guide
	  ▪ Entitlement Self Assessment
	  ▪ Online Claim for Liability
	  ▪ Eligibility and Claim Factsheets
	  ▪ A-Z Guide to DVA Services
	• Veterans' Access Network and General Enquiries Line
	• Claims Assessors
	• Case Coordination team to assist clients at risk of self harm or harm to others, to navigate DVA services
	• Single point of contact for clients with complex/multiple needs
	• Enhanced pathways initiative (currently in development)
	• Dedicated DVA team (located in Victoria) to receive and manage all new claims for sexual and other forms of abuse
	• Veterans' Review Board (VRB)
	• Administrative Appeals Tribunal (AAT)

Other - *advocacy services available through Ex-Service Organisations*	

Statements of Principles

Legislative reform in the mid-1990s led to the establishment of the Repatriation Medical Authority (RMA), to create a more equitable and consistent system of dealing with claims for compensation received by DVA from Australian veterans and their dependants. The role of the RMA is to determine Statements of Principles (SoPs) for any disease, injury or death that could be related to military service, based on sound medical-scientific evidence. The SoPs state the factors that 'must' or 'must as a minimum' exist to cause a particular kind of disease, injury or death[19] and enable a determination by DVA Claims Assessors for a claim under one or more of the relevant Acts for liability, compensation, income support and/or rehabilitation.

The Committee was of the view that consideration should be given to reviewing the current SoPs to ensure appropriate coverage of female specific conditions. The Committee was concerned that limited coverage of female specific conditions in the SoPs might limit current and former serving female Members in:

- accessing entitlements for all conditions that could be related to Service; and
- not being validated as a veteran.

Examples discussed by the Committee in relation to forming this view are outlined below. Further, Dr Crompvoets' report also highlighted the view held by participants in her study that DVA legislation was not seen to accommodate a range of women's health issues.[20] There is potential for assessment tools such as the SoPs to be revised to better account for female physiology.

Example 1

The RMA website provides lists of SoPs and conditions by category on the webpage www.rma.gov.au/SOP/main. The only gender-specific category for women is 'Pregnancy, Childbirth and Puerperium'. However the linked webpage is blank and the category does not have any SoPs attached to it. This is the only category within the SoPs that is blank and could reinforce negative views from those accessing the webpage about non-legitimacy of the female veteran status. Subsequently, the RMA have agreed the link will be removed.

Example 2

A range of SoPs were reviewed by the Committee for female inclusiveness. In particular, the SoPs 43/2013 and 44/2013 for the condition of 'erectile dysfunction' was discussed. The Committee felt that both genders should have access to an accepted condition (as males do with erectile dysfunction). The Committee recommends the Commissions request the RMA to investigate whether SoPs can be determined for female sexual dysfunction.

The RMA provided information to the Committee that SoPs currently cover 317 causes of disease and injuries, but do not cover every existing disease or injury. Eligible veterans and organisations can ask the RMA to investigate whether SoPs can be determined for a particular kind of disease or injury (but not a symptom). All veterans can make a claim for a pension even where there is no SoP for a condition. The Committee was satisfied with this response but considered whether this information could be made more widely available.

[19] RMA website www.rma.gov.au

[20] *The health and wellbeing of female Vietnam and contemporary veterans*, p.23

Preferences for communication with female staff

At times, women may prefer to talk to women about issues relating to the claiming process. The Committee felt that access to female DVA staff should be arranged if a female client requests this. This is in recognition of sensitive issues that may arise in the claims process including gynecological, reproductive or sexual health issues; relationship; or parenting issues.

Some business areas of DVA already have the flexibility in staffing to accommodate this option.

The Committee was advised that the On Base Advisory Service has female advisors available at the majority of bases. In addition, there are several female Veterans' Review Board Members and when requested, a panel can be convened that has a majority of females or is all-female.

Female representation in ESOs

> …there wasn't a lot of women. So they found it quite daunting to deal with a women first off, and… also look at her and go OK, well what has she done?
>
> Peacekeeping, Army, other occupation, 40[21]

When submitting a claim for compensation to DVA, clients may want to utilise the services of a trained practitioner or advocate to guide them through the process, usually through an ESO. Although no specific figures on the gender breakdown of advocates is held by DVA, anecdotal evidence from Committee Members familiar with the ESO community reports that the majority of pensions and welfare officers are male. The Committee encourages ESOs to actively increase the numbers of female advocates and recommends that DVA communicate the benefits of recruiting female advocates to ESOs.

Further, the Committee found that no specific female representation from ESOs was sought by DVA as part of its current National Consultative Framework, and saw this as a gap. The Committee recommends that DVA request female veteran nominations from ESOs for the National Consultation Framework.

Recommendations

7. DVA, through its Commissions, make a request to the RMA to investigate whether SoPs can be determined for female sexual dysfunction.

8. That DVA consider arrangements to enable female clients to speak with female DVA staff members, when requested.

9. That DVA encourages ESOs to recruit female advocates.

10. That DVA consider directly requesting female veteran nominations from ESOs to be part of the National Consultative Framework.

[21] *The health and wellbeing of female Vietnam and contemporary veterans* p.62

4. Member Support

Member Support encompasses all the administrative support activities necessary to ensure optimal wellbeing for the Member and their family as they deal with the issues arising from their health condition. If the Member is still serving, the main responsibility for this process sits with Defence.

The Committee considered the range of service offerings by Defence and DVA, detailed at Table 5.

Table 5: Defence / DVA service offerings considered by the Committee

Defence	DVA
• Member Support Coordinators • ADF Rehabilitation Program (Case Manager) • ADF All Hours Support Line (1800 628 036) • Defence Family Helpline (1800 624 608) • SeMPRO 24/7 support service (1800 SEMPRO, also includes sms and email options)	• DVA On Base Advisory Service • Veterans and Veterans Families Counselling Service website and all hours counseling service

Committee discussions focused on two issues:

- Member and Family Welfare Support; and
- Member Support Coordination.

Member and Family Welfare Support

The Committee discussed Defence reviewing communication material to ensure broader representation of a range of possible Member family situations including:

- civilian female spouses as partners;
- civilian male spouses as partners;
- dual serving couples;
- same sex couples;
- those with children;
- those without children; and
- responsibilities for their elderly parents.

The Committee noted a range of examples where good practice is already occurring, including material provided by the Defence Community Organisation (DCO). The Committee were also impressed with the Air Force Diversity Handbooks available to Air Force personnel including:

- *Flying through parenthood – a parental planning guide for women aircrew*;
- *Supporting breastfeeding mothers in the workplace*;
- *Handbook for sole and non-custodial parents*;

- *Handbook for Lesbian, Gay or Bisexual Members*; and
- *The Working Parents Toolkit*.

The Committee supports these information publications and would like them to be more widely available. Air Force is considering providing relevant titles to female Members on receipt of applications for maternity leave. The Committee supports this approach.

Officials from DCO briefed the Committee on the Defence Family Helpline service, that has been in operation since February 2012. The Helpline provides a 24 hour intake service for ADF Members and their families focused on assessment, brief intervention and referral. The majority of callers are ADF Members (51 per cent Army, 27 per cent Air Force, 19 per cent Navy), with spouses and mothers of serving personnel also making contact. Peak usage times are the evenings and on weekends.

The Committee was impressed with the flexibility, accessibility, client control (when to call, how much to say), immediacy and anonymity of the service. In 2012, the most common groupings/primary presenting issues were:

1. Family assessments (970 calls)
2. General enquiries / other (599 calls)
3. Relationship Issues (458 calls)
4. Coping strategies (354 calls)
5. Compassionate posting (345 calls)

There is an increasing trend for calls relating to mental health issues, for which Helpline callers are mostly referred to VVCS. The Committee supports the work of the Helpline and encourages DCO and VVCS to explore options to strengthen the links between the organisations to enable discussion of de-identified cases and trends with a view to improving the continuity of services.

The Committee was also briefed on the On Base Advisory Service (OBAS) provided by DVA since October 2011. Through OBAS, DVA is implementing a process to encourage the lodgement of claims for compensation at the time a Member is wounded, injured or ill. This will lead to an improved handover to DVA at the time of the Member's separation from the ADF. The Committee was impressed by the OBAS initiative, although noted that statistics were not kept on female ADF personnel accessing the service. The Committee recommends a review to see if gender usage data can be reported.

Member Support Coordination

Member Support Coordination includes the provision of dedicated support, coordination and facilitation to an individual Member and their family facing complex circumstances as a result of their health condition. The service is a tailored version of Member and Family Welfare Support, coordinated through the Member's Commanding Officer.

The Committee particularly considered Member Support Coordination for those who have suffered sexual trauma and other abuse.

One of the findings in Dr Crompvoets' report relates specifically to support for issues relating to military sexual trauma. A small number of women in the study had experienced sexual abuse (rape or assault), a larger number of women mentioned other types of harassment (name calling, derogatory remarks about their sexuality or body image). Impacts of sexual harassment or abuse included:

- Sexual dysfunction;
- Social isolation;
- Anxiety;
- Depression;
- PTSD;
- Relationship breakdown; and
- A premature end to ADF career.[22]

The Committee welcomed the July 2013 implementation of the Sexual Misconduct Prevention and Response Office (SeMPRO) to support ADF personnel who are victims of sexual misconduct.[23]

SeMPRO was established in response to recommendations in the 2012 *Review into the Treatment of Women in the ADF – Phase 2 Report*. SeMPRO allows confidential reporting of allegations of sexual misconduct or inappropriate sexual behaviour to be made by Defence Force personnel outside of the chain of command. SeMPRO uses a victim oriented approach. SeMPRO provides trauma support to victims of sexual misconduct, advice to commanders and managers on managing these reports, as well as a preventative and educative role in the wider ADF.

In 2012, DVA implemented policies and processes to respond to clients who have experienced sexual abuse or other trauma[24], including:

- implementation of a dedicated, specially trained team located in the Melbourne DVA office to receive and manage all new claims for sexual and other forms of abuse;
- the provision of a Departmental single point of contact to support each client through the claims process; and
- sensitivity in the referral of any clients for specialist medical examinations e.g. women are offered an appointment with a female medical specialist if required.

The Committee noted the actions taken by Defence and DVA relating to sexual misconduct and concluded they addressed the issues raised in Dr Crompvoets' report.

The Committee also considered the services available to support ADF Members and their families experiencing domestic violence. Safe accommodation is available through DCO for serving Members and their families. Help is also available through VVCS for former serving personnel in the Crisis Assistance Program (CAP). The Committee noted that CAP seemed to be focused solely on Vietnam veterans and were concerned that it may not meet the needs of all VVCS clients.

[22] *The health and wellbeing of female Vietnam and contemporary veterans*, p.31

[23] A SeMPRO brochure defines 'sexual misconduct' as criminal offences of a sexual nature such as assault, rape and acts of indecency. It also includes serious incidents of a sexual nature which can cause trauma i.e. extreme exclusion based on gender, sexual orientation or gender identification; persistent unwanted/unwarranted attention of a sexual nature; and/or recording, photographing or transmitting incidents and/or images of a sexual nature.

[24] A Defence Abuse Response Taskforce (DART) reparation payment does not automatically mean acceptance of a DVA claim in relation to sexual or other trauma.

Recommendations

11. Diversity publications to be made more accessible for all ADF Members.

12. Defence and DVA consider integrating information from DCO and VVCS to identify ‘hotspots’ enabling more targeted prevention initiatives.

13. DVA investigate whether or not the On Base Advisory Service can report the gender breakdown of ADF Members accessing the service.

14. VVCS review its Crisis Assistance Program (CAP) to ensure it meets the needs of contemporary veterans and their families.

5. Return to Work

Return to work encompasses activities outside the health care and recovery processes that are required to return a Member to the ADF work environment. The Committee focused its discussion on female ADF Members returning to work post-partum.

Post-partum return to work

As discussed earlier in this report, ADF servicewomen have access to high quality medical care that provides pre and perinatal care through contracted health professionals off-base.

Policies relating to post-partum return to work are Service-specific and the Committee discussed issues relating to fitness requirements and testing following pregnancy. Following return to work post partum, ADF Servicewomen have 90 days to achieve return to work fitness assessed via a fitness test (standards differ depending on age and the Service).

Given the significant variability in when female Members return to work post partum, the Committee felt the period of time specified for them to meet their Service's fitness standards should be reviewed. Recently, and as a direct result of the Committee's discussions on this topic, Army have taken steps to increase the timeframe from returning to work until the first fitness test to 180 days. The Committee applauds this action.

The fitness test includes elements designed to test abdominal strength. This, in turn, focuses training in preparation for the test on one set of abdominal muscles. However it is important that female Members undertaking post partum training also focus on strengthening pelvic floor muscles and other internal supporting structures.

A positive example from the United States is the US Army's Pregnancy/Post-Partum Physical Training Program that helps Servicewomen maintain health and fitness and prepares them for their Army Physical Fitness Testing.[25] The Committee is not aware of similar fitness training in the ADF that allows for a graduated return to fitness as appropriate to the circumstances of the individual Member. Nor is the Committee aware of the training that Physical Training Instructors (PTIs) have in post-partum health and fitness issues.

The Committee is supportive of a point of contact being developed in the ADF to help servicewomen meet their Defence-specific occupational requirements after pregnancy. For example, this may include the appointment of a 'Health and well being' manager for each Service, or via Joint Health Command. This contact could assist with better links for care of perinatal mental health, physical training or administrative issues.

It was noted that the Air Force are working to become an accredited workplace with the Australian Breastfeeding Association to provide a supportive environment for breastfeeding mothers to return to work. The Committee supports this initiative.

The Committee considered that the research taking place within the 'Mothers in the MEAO' project will be very useful and noted the focus on the health impacts of maternal deployment.

[25] *Pregnancy and Childbirth: A goal oriented guide to prenatal care*, p.95.

Recommendations

15. Consideration be given to the development of graduated and flexible post partum return to fitness programs that are responsive to the circumstances of individual members.

16. Consideration be given to increasing the awareness of PTIs of post partum health and fitness issues.

17. Consideration be given to a point of contact being developed in the ADF to assist females meet their Defence-specific occupational requirements, particularly in the post natal period.

6. Transition

The transition process encompasses those activities required to transition a Member, who is separating from the ADF on medical grounds, into civilian life. Defence has responsibility for transition services and Members separating from the ADF are assisted with the separation process through the Defence Transition Support Services. The Committee considered the range of service offerings by Defence and DVA, detailed at Table 6.

Members separating from the ADF attend transition seminars run by Defence. DVA OBAS staff attend these seminars as a way of connecting separating Members with DVA. OBAS actively provides information for ADF Members about DVA payments and services, and provides assistance to Members who wish to lodge claims for compensation with DVA. The response from Defence personnel to this initiative has been very positive.

DVA is implementing a process to encourage the lodgement of claims for compensation at the time a Member is wounded, injured or ill. This will lead to an improved handover to DVA at the time of a Member's separation from the ADF.

The Committee considered the process of transition as relating to Reservists transitioning from Continuous Full Time Service (CFTS) back into civilian life as well as Regular / Permanent Members discharging from the ADF.

Table 6: Defence / DVA service offerings considered by the Committee

Defence	DVA
• Defence Transition Support Services (Regional transition centres, transition seminars, website, links to other government and community services) • Defence Family Helpline 1800 624 608 • ADF Transition Booklet	• OBAS • DVA website ▪ Benefits Guide ▪ Entitlement Self Assessment ▪ Online Claim for Liability ▪ Eligibility and Claim Factsheets ▪ A-Z Guide to DVA Services • Veterans' Access Network and General Enquiries Line • Veterans and Veterans Families Counselling Service (VVCS) website and all hours counseling service • VVCS Stepping Out Program

The Committee noted no gaps in relation to transition for Regular / Permanent ADF Personnel. Services are available and being utilised through the Defence Transition Support Services and the ADF Transition Centres, which provide information on, and link Members into, Defence and other government support agencies, such as:

- ADF Rehabilitation Program;
- Defence Community Organisation;
- Department of Veterans' Affairs (through OBAS);
- ComSuper;
- Centrelink;
- advice on Defence procedures, such as choosing separation dates;

- assistance with completing Defence requirements; and
- assistance for the Member and their family with becoming ready for separation.[26]

Approximately 18 per cent of ADF personnel who accessed Defence Transition Support Services are female. This figure is consistent with the average female participation figure across the ADF (14.5 per cent). The Directorate of Defence Transition Support Services provided the following breakdown of the 2012 utilisation of their service:

- 1476 Navy personnel of which 21 per cent were female;
- 4097 Army personnel of which 10 per cent were female; and
- 1026 Air Force personnel of which 21 per cent were female.

These figures were noted as being slightly higher than the respective female participation rates in the Navy and Air Force and around the same for Army (18.4 per cent, 17.7 per cent and 11.1 per cent respectively).

Transition services were thought to be extremely well utilised. The Committee noted the process for Members to connect with ADF Transition Centres is well established. When a Member notifies their Unit of their intent to leave the ADF, advice is received by Transition Support Services and the closest Transition Centre makes contact with the Member. However, it was explained that the Member is often already aware of support provided by ADF Transition Centres and it is often the Member who initiates contact.

ADF Transition Centres are an example of a service that has a family-friendly focus. Serving Members and/or partners of serving Members bring children to the Centres and families are encouraged to attend with the Member. DVA services, including VVCS, should look to replicate this model where possible.

ADF Transition Centres were viewed by the Committee as having a positive working relationship with the DVA On Base Advisory Service. ADF Members who access the Centres can opt to sign a consent form to indicate that they are interested in receiving more information about DVA. This initiates a signal to OBAS, who then makes contact with the Member. The Committee were impressed at this proactive contact from DVA with the Member.

The Committee spoke with an On Base Advisor based in the NSW/ACT region. The advisor stated that many younger Servicewomen visit and utilise OBAS. They ask about possible benefits; what they might receive as partners of veterans and to find out more information on behalf of their partner. While this was only an observation on the experience of one On Base Advisor, the types of enquiries described lead the Committee to note that ADF servicewomen do not necessarily consider themselves veterans in the OBAS context. This is another example where targeted communications for ADF servicewomen would be useful.

The Career Transition Assistance Scheme (CTAS)

The CTAS assists ADF Members for their next career after separation. Significant features of the CTAS are that:

- assistance is a condition of service and is available at different levels to eligible Members;
- entitlements are available for up to 12 months after separation; and

[26] http://www.defence.gov.au/transitions/my_nearest_adf_transition_centre.htm

- additional assistance is provided to Members who are declared redundant, have reached compulsory retirement age or whose service is terminated for medical reasons.[27]

Access to the various levels of CTAS is dependent on the length of service and/or the circumstances surrounding the ADF Member's separation. The Committee heard that CTAS is currently being reviewed. The Committee supported this, particularly if it allows more female serving Members to access the program. The Committee queried whether the same eligibility for CTAS entitlements should apply if the Member has been a victim of sexual abuse in the ADF and leaves as a result of this abuse.

Transition and Reservists

> Good post-deployment workplace support for Reserves was reported with about two-thirds reporting no loss of income, seniority or opportunity for promotion, or resentment by co-workers; this proportion was 80-90 per cent among those who stated the questions were relevant to them. However, around 10% did report problems. These results suggest that stronger reintegration support for Reserves may be needed, both for Members who deployed as reserves on CFTS and those who left the regular forces and joined the Reserves after deployment.
>
> *MEAO Census Study Summary Report*, p.46

The Committee noted that Reservists face different challenges to their regular/permanent counterparts relating to management of their civilian and military life, deployments, post operational assistance and support for their families. These unique characteristic create possible gaps in a Reservist connection with both Defence and DVA.

The Committee is aware that a review of post-operational support for Reserve Members was completed in 2012 by Colonel F.R. Skowronski. The Committee supported this review, with particular reference to the following findings:

- The unique nature of Reserve service may require Reserve-specific demounting procedures, in order to ensure that Reserve Members are suitably prepared for transition and reintegration into their units, civilian workplaces and communities.[28]
- Conditions of service entitlements for Reserve Members who have completed their post-deployment CFTS are not well articulated, particularly for mental health issues not immediately associated with their CFTS.[29]
- There is no 'one-stop-shop' for Reserve Members once they return to their parent units, to receive advice on their post-operational entitlements and how these may be accessed.[30]

Though the Skowronski Review did not focus on gender, these three findings align with Committee discussions on female Reservist's access to services and the unique experience of Reservist transition from CFTS back into civilian life. The Skowronski Review found that 'Reserve Members are entitled to the same post-operational support as Regular Members'[31] however, this was not the view commonly held by Reservist Committee Members.
The Committee recommends that Defence and DVA should make information about services and supports clearer and easier to access, to increase use by Reservists.

[27] *The ADF Transition Handbook*, p.11
[28] *Review of Post-Operational Support for Reserve Members*, p.1
[29] *Review of Post-Operational Support for Reserve Members*, p.3
[30] *Review of Post-Operational Support for Reserve Members*, p.3
[31] *Review of Post-Operational Support for Reserve Members*, p.3

DVA has recognised that more needs to be done for Reservists as a client group and has been more proactive in communicating with Reservists and their families. Feedback from the Reservist Members of the Committee has been provided to the DVA business area currently overseeing a review of service delivery policy in relation to Reservists.

Recommendations

18. Defence consider whether Members whose separation from the ADF is related to a traumatic incident (i.e. where a person has been a victim of sexual assault), should be automatically eligible for assistance through CTAS.

19. Defence and DVA review information about services for Reservists, and how that information is provided, to ensure Reservists are fully aware of the services and supports available to them.

7. Post Transition Care and Support

This process has a focus on maintaining and enhancing wellbeing, self sufficiency and quality of life for former serving ADF Members and their families. Post transition care and support is led solely by DVA through the provision of health and other care and support services through DVA, which promote early intervention, prevention, treatment and self-reliance.

> There was overwhelming consensus amongst research participants that DVA was an organisation that only accommodated the needs of males, in particular older males.
>
> Dr Samantha Crompvoets

Support services and entitlements provided by DVA can be categorised as:

- Health care, information and treatment;
- Financial support and assistance;
- Rehabilitation (physical training, psychosocial intervention and vocational education and training);
- Emotional support (trauma/guilt/grief) and psychological support; and
- Information and communication materials.

The Committee considered a range of service offerings by DVA, detailed at Table 7.

Table 7: DVA service offerings considered by the Committee

DVA service area	Provision via
Health care	• Repatriation Health Cards (Gold, White, Orange) • Primary Health Care • Hospital Care • Non-liability health cover (including mental health treatment) • Aids and appliances • Repatriation Pharmaceutical Benefits Scheme (RPBS) • Home care assistance
Financial support and assistance	• Income Support payments • Incapacity benefits • Compensation payments • Community grants (through ESOs)
Rehabilitation	• Medical Rehabilitation • Vocational Rehabilitation • Psychosocial Rehabilitation
Counselling services	• VVCS
Information and resources communication	• Brochures • Factsheets • Promotional materials • DVA website • DVA Twitter and Facebook accounts

The Committee were briefed that DVA is a major national purchaser and provider of health care services with approximately $5.5 billion annually. To provide access to a broad range of health services, DVA has purchasing arrangements from public, private and non-profit organisations in the health sector spanning General Practitioners, hospital services, allied health services, home care services, community nursing, transport to and from medical appointments, pharmaceuticals, mental and social health services and aged care services.

Access to DVA health care services is provided for conditions that are accepted as having been caused by military service. Services are initiated by the Member – current and former serving Members must make contact with DVA to lodge a claim.

The Committee noted that increasingly, DVA is working with Defence to facilitate early, proactive contact with Members. The On Base Advisory Service (OBAS) is building stronger ties with ADF Health Centre and ADF Transition Centre staff who can direct personnel to DVA through OBAS. The Committee also noted that there is an increasing focus on non-liability health care where DVA covers the cost of treatment for diagnosed mental health conditions including post traumatic stress disorder, anxiety or depression – without the need for a claim.

Barriers to Access

> If you do not see yourself as a legitimate veteran and if others do not see you as a legitimate veteran, it makes those barriers much harder for you individually or for your family to reach into the services that may be best to meet your needs.
>
> Associate Professor Susan Neuhaus, CSC

The broad range of services provided by DVA was noted. However, the Committee recommends that further work needs to be undertaken to understand and address barriers to current and former serving female Members accessing these services. The lack of a female veteran identity is seen as a major barrier to access.

The Committee considers the visibility of female veterans must be enhanced in order to make DVA services relevant and accessible for this cohort. Mental health resources available through the DVA At Ease website are a good example of veteran inclusiveness. The Committee recommends the DVA website, especially the women's health resources should be updated (as recommended at Chapter 2) to provide a dedicated space for female veterans.

A further good example of gender-specific resources is the United States Department of Veterans Affairs website. A screen shot of this is at Figure 1 on the following page.

The Committee is concerned that significant numbers of female veterans may be accessing health services through the general health system for service-related conditions, because they do not feel DVA services are an option for them.

DVA promotional and information material can greatly impact on breaking the barriers to access for female veterans. As recommended in Chapter 2, the Committee believes a gender lens should be applied to all DVA information campaigns to ensure inclusive language and images. If the reader can relate to the information products they are more likely to initiate contact with DVA.

Figure 1: Women Veterans Health Care Home Page http://www.womenshealth.va.gov/

'Have you served?'

The Committee suggests a dedicated website such as the US example above, can be part of an active campaign to 'pull' women into DVA services and to raise the visibility and self identification of female veterans in the serving, ex-serving and wider Australian community. An example that DVA has undertaken for another cohort of clients who may not readily identify themselves as veterans includes Aboriginal and Torres Strait Islanders. This campaign began in 2007 to better connect with the Indigenous veteran community through the tagline *'You served your country – Veterans' Affairs would like to help you'*.[32]

The Committee recommends that DVA give consideration to developing a targeted communications strategy for connecting with female veterans. The Committee felt strongly that clear, inclusive language is key in how DVA needs to get its message to this cohort. A tagline for the campaign might be as simple as 'Have you Served?'.

Elements of a targeted communications strategy might include:

Female Veterans' Stories of Service
Telling the stories of what women have done in the military (highlighting that they are not only working in a caring/medical support role) and in their own words, what they've achieved in Service. Could link to existing resources including:

Video interviews on the Australian War Memorial website for the exhibition *Afghanistan: the Australian Story*:
http://www.awm.gov.au/exhibitions/afghanistan-australian-story/interviews/

Video interviews on the DVA At Ease website:
http://at-ease.dva.gov.au/veterans/resources/videos/

Champions for female veterans
Interviews or statements with champion figures in the community for female veteran issues. This could be medical practitioners who specialise in women's health and are also DVA providers. Current serving male and female high ranking ADF Members could also be approached.

Facts and Statistics
Make statistics on female veterans available and keep regularly updated (i.e. quarterly).

[32] http://www.dva.gov.au/benefitsAndServices/ind/Pages/youserved.aspx

Childcare

The Committee noted that in her report, Dr Crompvoets identified a lack of childcare and family friendly spaces are a barrier for female veterans accessing services.[33]

DVA has provisions through rehabilitation entitlements for emergency childcare, however the Committee thought that the difficulties accessing childcare as a possible barrier to accessing services required further consideration by DVA. Options discussed by the Committee included:

- ensuring DVA service providers are mindful of DVA clients with children and that appointments are able to be made at convenient times i.e. while children are in school or alternative care; and
- ensuring VAN and VVCS offices are located within a reasonable distance of childcare options and that VAN officers and VVCS staff can provide details of childcare options in their area.

Peer Support

The Committee discussed the importance of peer support for current and former serving female Members.

A recent post on the DVA Facebook page by a female veteran following a visit to a Veterans' Health Week 2013 expo demonstrates both frustration with accessing female specific information, and the importance of peer support. The veteran writes:

> …there was no health information for them [female veterans]… we are Veterans not 'wives and partners of Veterans', this was just another kick in the guts for our female Veterans who work so hard to cope to not only have served and be a Veteran but also be a mother and wife and deal with PTSD on top of it all.

In a subsequent post she writes:

> …so many women…actively looking for support groups that don't involve men so they can speak freely of their experiences and also learn to cope with day to day chores being a mother, wife, civilian, working in Civvi street and coping with depression, anxiety disorders, PTSD and health/wellbeing and fitness.

The Defence Community Organisation maintains a list of community groups on their 'community connect' website[34] which includes events like regular coffee mornings, support groups and one-off social events that those in the Defence community may attend.

The Committee recommends that DVA develop resources for the veteran community on how they can start their own community group in their local area. A list of events divided by region could be maintained and made available through the DVA website. It could also be investigated whether formation of community veteran groups could be funded via DVA grants programs – if so, this information could be linked on the website.

[33] *The health and wellbeing of female Vietnam and contemporary veterans*, p.29

[34] http://defence.gov.au/dco/Community_connection.htm

VVCS plays an important role in the provision of emotional and psychological support through individual and group counseling sessions. VVCS has the capacity to provide a range of female-only treatment groups, however there are no groups specifically for female veterans. Demographic data by location should be reviewed by VVCS and information about female specific group programs should be provided in areas of increased female veteran usage of VVCS services.

Provider Awareness

The Committee noted in the mental health package announcement with the 2013 Defence White Paper, a measure included referred to implementing a post discharge GP health assessment, using a specially developed screening tool for former ADF Members including Regular / Permanent and Reserve forces.[35] The Committee saw this as a positive step and recommends the needs of female veterans be taken into account in the development of this initiative. Further, a continued focus on health provider education with respect to the needs of different client cohorts, including female veterans could be undertaken by DVA. This may further assist linkages with female veterans and healthcare providers.

Recommendations

20. DVA undertake an active campaign to make female veterans aware of DVA services.

21. The location of childcare options to be taken into consideration for the location of all future VAN/VVCS offices.

22. DVA develop resources to assist veterans to develop their own support groups in their local area, with DVA to maintain details of groups available on its website.

23. VVCS review demographic data by location to identify areas of higher female veteran usage with a view to holding female-only veteran group programs.

[35] *Prime Minister, Minister for Defence and Minister for Defence Science and Personnel - Joint Media Release – 2013 Defence White Paper: Support to ADF Personnel*, p.1

8. Support Continuum Performance and Reporting

The principles that underpin the coordinated delivery of support are set out in the *Memorandum of Understanding (MoU) between Defence and Veterans' Affairs for the Cooperative Delivery of Care and Support to Eligible Persons*, which was signed on 5 February 2013.

Under the MoU the Defence DVA Executive Committee (DDEC) is the principal governing body responsible for setting the joint strategic direction for the delivery of care and support. Membership of DDEC comprises the Chief of the Defence Force; Secretary, Department of Defence; and Secretary, Department of Veterans' Affairs.

The Defence Links Steering Committee (DLSC) is responsible for implementing the strategic direction set by the DDEC. The DLSC is co-chaired by the Deputy President of the Repatriation Commission (DVA) and the Deputy Secretary Defence People (Department of Defence).

As mentioned previously, the Support Continuum sets out the framework of key roles and responsibilities within the Support Continuum in order to promote a broad understanding, within both Defence and DVA, of the accountabilities and key responsibilities, the primary interrelationships and key information flows involved in the provision of effective care and support.[36] The principles that have been agreed upon for providing support across the Support Continuum are outline at Figure 2:

Figure 2: Defence/DVA MoU **-** Agreed Principles

We will work together to ensure that wounded, injured or ill ADF Members and their families are supported and cared for during and after their service.

We will define funding arrangements for the provision of this care and support. Defence is responsible for funding care and support for serving Members until an agreed point of transition.

We will share information between Departments, resolving issues related to privacy and consent, to ensure assessment and liability is determined as close as possible to the time that the injury occurs.

We will ensure all communication with wounded, injured and ill Members, and supporting agencies, reflects the joint responsibilities of both Departments.

We will collaborate on policy and program development and engage on emerging issues affecting both Departments.

We will measure and report our joint responsibilities for the care and support of wounded, injured or ill Members.

[36] *Schedule 16 to the MoU between Defence and DVA: Support for Wounded, Injured or Ill – Framework of Roles and Responsibilities*, p.6

The ongoing effectiveness of the Support Continuum is measured using agreed performance metrics from both Defence and DVA.[37] The DLSC is accountable for the effective functioning of the Support Continuum and a brief on the Support Continuum Performance Metrics is prepared by the SWIIP Program Manager (Defence) for each meeting of the DLSC.

Enhanced reporting

The Committee notes that while each DLSC meeting considers detailed reporting on the Performance of the Support Continuum there is no gender specific data presented. Gender specific data sets would assist DLSC to consider whether or not there are any gender specific issues requiring action.

ADF incident data reporting is an example of one reporting element that may benefit from gender disaggregation. Incident data relates to the 'Prevention' process in the Support Continuum. Reporting to DLSC includes incident by causal factor and by mechanism. Examples are at Table 8.

Table 8: Examples of incident data sets used in Support Continuum performance reporting to DLSC

Causal factors	Incidents by Mechanism
• Physical Training (PT) • Operational duties • Combat training • Driving • Operational combat • Manual / Materials Handling	• Chemicals and Other Substances • Body Stressing • Falls, Trips and Slips by Person • Biological Factors • Sound and Pressure • Mental Stress

Incident data is presented by Service, with separate figures for Permanent and Reserve forces. Consideration of incident data by gender would allow DLSC to consider whether or not there are any casual factors or mechanisms with a higher incidence rate for female ADF Members.

Other performance reporting data that may be useful to be broken down by gender includes:

- ADF Rehabilitation Program data in the Healthcare and Recovery process;
- Claims data in the Liability Determination process;
- Medical Classification Review Board (MECRB) Outcomes in the Return to Work / Transition processes;
- Separation data in the Transition process; and
- Data relating to the Post Transition process.

The Committee recommends that DLSC considers the current Support Continuum Performance Report with a view to disaggregating appropriate elements to facilitate consideration of gender specific issues.

[37] *Schedule 19 to the MoU between Defence and DVA: Support Continuum Performance Metrics Framework*, p.2

Recommendation

24. DLSC investigate the possibility of Support Continuum performance reporting by gender (where relevant) to ensure Support Continuum processes are meeting the needs of the female cohort.

Conclusion

The ADF Service Women Steering Committee has reviewed the current state of service delivery across Defence and DVA through the prism of the Support Continuum process. The Committee was impressed with the range of services both Departments provide to all current serving Members, former serving Members, Reservists and their families. However, the Committee was concerned that services and supports are not reaching female veterans and their families as well as is required.

There is an opportunity to change perceptions in the serving and ex-serving community through:

- an ongoing 'recruitment' campaign by DVA to communicate to current and former female Members what services and supports are available and how they can access them; and
- a central access point for information across Defence and DVA that clearly outlines provision of support.

This would enable Members or former Members and their families to more easily find what they need, when they need it.

Reinforcing key messages to current serving Members is also likely to improve health and wellbeing outcomes and qualify expectations:

- It is in the ex-serving Member's interest to make and maintain contact with DVA as early as possible; and
- A veteran identity is about Service first and foremost rather than having a DVA claim accepted.

The Committee is of the view that in order to provide targeted support for female veterans, a better understanding of the available data is needed. The DLSC is seen as an excellent joint Defence/DVA governance mechanism to ensure that the Support Continuum process is meeting the needs of female Members.

The Committee believes the 24 recommendations presented in this report are practical suggestions that will advance outcomes for current and former serving female Members and their families.

In conclusion, Table 9 outlines how the 24 recommendations from the Committee link with the seven key recommendations from Dr Crompvoets' report. Of the 24 Committee recommendations, six are specific to Defence, eleven are specific to DVA and seven are relevant for both Defence and DVA.

The Committee would like to thank both DVA and Defence for the opportunity to explore their respective service delivery models.

Table 9: Alignment of Committee recommendations with *The health and wellbeing of female Vietnam and contemporary veterans* report recommendations.

Overview of recommendations from *The health and wellbeing of female Vietnam and contemporary veterans* report	**Corresponding ADF Service Women Steering Committee recommendation numbers**
Develop targeted support and resources for female veterans	1, 2, 3, 8, 9, 11, 15, 16, 17, 18, 19, 20, 22, 23
Increase the visibility of services for and experiences of women	2, 3, 6, 7, 8, 9, 10, 11, 12, 13, 15, 17, 19, 20, 22, 24
Facilitate continuity of learned coping strategies post-discharge from the ADF	2, 3, 11, 12, 17, 22, 23
Implement and evaluate family friendly practices	12, 14, 21
Provide training to civilian health care providers on issues for female veterans	7, 16
Develop best practice guidelines for the treatment of female veterans	5, 12, 16
Set a strategic research agenda on female veterans health[38]	4

[38] Work is currently underway in Defence which the Chief of Defence Force is engaged on. A workshop is proposed for 2014 to discuss further. Defence are also aligning with DVA's strategic research agenda framework which refers to female veteran health.

Appendix A

Member Biographies

Committee Members at the meeting of 28 August 2013

Back Row L-R: Anne Pahl, GPCAPT Margot Forster CSM, MAJGEN Gerard Fogarty AO, CMDR Jill Buckfield, Julie Blackburn.
Front Row L-R: Sam Jackman, WO2 Jenni Smith, Gayle Anderson, COL Natasha Fox CSC, Catherine Mahoney.

Major General Gerard Fogarty AO was Head of People Capability, having assumed this appointment in June 2011 until his retirement from the Army in November 2013. He held a wide-range of strategic level staff appointments in Army and Defence Headquarters. Gerard was also a Commissioner on the Military Rehabilitation and Compensation Commission and a Deputy Commissioner on the Safety Rehabilitation and Compensation Commission.

Gerard and his wife Mandy have four children; Sam, Holly, Georgia and Olivia. His leisure interests include transporting his children to their many sporting commitments, cycling and playing the guitar.

Gayle Anderson is the Assistant Secretary, Client Strategy and Defence Relations Branch, Client and Commemorations Division, Department of Veterans' Affairs. Gayle joined the Department in June 2012 having worked in a broad range of areas in the Department of Health and Ageing for the last 10 years. She has experience in working for State Governments, the academic sector at both the Queensland University of Technology and Queensland University and in private enterprise. Gayle holds a Bachelor of Science, Graduate Diploma of Nutrition and Dietetics and a Master of Health Science.

Colonel Natasha Fox, CSC entered the Australian Defence Force Academy in 1988, graduated from the Royal Military College in 1991 and the Australian Army Command and Staff College in 2003. She has operational experience through a deployment to the United Nations Truce Supervision Organisation serving in Lebanon and Syria. She has also deployed on Operation SLIPPER to Headquarters Joint Task Force 633 as the Chief of Staff during the period June 2012 – January 2013.

COL Fox's early career appointments related to logistics, training and planning and as Aide-De-Camp to the Chief of Army. COL Fox was appointed as Commanding Officer/Chief Instructor at ADFA (2009 – 2010) and received a Conspicuous Service Cross for her work during this posting. In 2011, she was posted as Staff Officer Grade One Personnel Policy at Army Headquarters (HQ) and in 2013 as the Director of Personnel Policy – Army. COL Fox is married to CMR Andrew Willis and has two children, Jack (7) and Riley (5).

Commander Jill Buckfield joined the Royal Australian Navy in 1986 after an eight year career with Telecom. During her 21 years in the permanent Navy she worked in a variety of roles including an acoustic analyst; intelligence officer; operational requirements manager for the acoustic suite on the Collins Class Submarine; military support officer; psychologist; and the Officer Commanding the Administration Cell in the Australian HQ in Baghdad.

After leaving the permanent Navy in 2007, she joined Defence as an APS psychologist and has worked at both the Australian Defence Force Academy and Duntroon Health Centres in clinical roles and staff officer positions in Mental Health Clinical Programs and Standards. CMDR Buckfield has maintained her active reserve status and completed a one year CFTS contract in 2008-09, working in a clinical role as a psychologist at Duntroon Health Centre and then as the SO2 in the Directorate of Psychology. CMDR Buckfield rejoined on a two year CFTS contract in February 2013 and is currently working in SeMPRO as a Support Coordinator.

CMDR Buckfield has a degree and post graduate qualifications in Psychology and is a registered psychologist with the Australian Health Practitioners Regulatory Authority. CMDR Buckfield lives on a country property where she pursues her passion for equestrian activities of horse riding and coaching.

Group Captain Margot Forster, CSM began her military career in the Royal Australian Navy in 1982 before transferring to the Royal Australian Air Force in 1988, her early roles in supply and unit administration. In the early-1990s, GPCAPT Forster lived in the United States with her husband and young family, and worked in the Australian Embassy, Washington DC. In 1995, they returned to Australia and full-time work within the RAAF including postings with Air Force Materiel Division, No 92WG and Air Force HQ.

In 2007, GPCAPT Forster was appointed as the Base Commander RAAF Base Williams and Commanding Officer Combat Support Unit Williams, for which she was awarded a Conspicuous Service Medal (CSM) on the 2009 Queens Birthday Honours List. In 2010, she deployed to the Middle East Area of Operations as the Commanding Officer Combat Support Unit, Al Minhad Air Base.

In 2012, Group Captain Forster was appointed as Director Pathway to Change, responsible for the coordination, reporting and oversight of Pathway to Change implementation within Air Force. GPCAPT Forster served in this role until January 2013 when she took up her current position of Chief of Staff Air Force Personnel Branch. GPCAPT Forster is married to Mike and they have three children, Rebecca, Christopher and Matthew.

Warrant Officer Class Two Jenni Smith enlisted in the Australian Army Reserves in 1996 specialising in logistics. She has spent seven years on CFTS and has fulfilled postings in recruiting, training and operations. She is currently posted to the 2nd Force Support Battalion as Platoon Commander of 6th Supply Platoon. WO2 Smith has served on operations in East Timor in 2000 as part of the United Nations Transitional Administration (UNTAET) in support of OP TANAGER and the Middle East in support of OP CATALYST in the operations cell for the Force Extraction Team in 2008.

In her civilian role, Jenni is the Operations Manager for Defence Reserve Support (Tasmania). Jenni is passionate about her role in the Army Reserves and supports the veteran community by providing advice and counselling to veterans and their partners. Jenni is married to Andrew, a Sergeant in the Army Reserves who was deployed to the Solomon Islands in support of OP ANODE in 2010-2011.

Lieutenant Commander Sam Jackman joined the Royal Australian Navy in 1987 after spending a year in the Royal Australian Air Force. On completion of her initial training at the Naval College at HMAS CRESWELL she spent time on board HMA Ships NIRIMBA, WATSON, JERVIS BAY and TOBRUK. LCDR Jackman spent three years as a communicator on the Sea Training Group, spending time at sea on most Major Warships as well as Minor War Vessels during their work up periods. In 1993, LCDR Jackman was again posted to HMAS WATSON as the Training Administration Officer and subsequently the Aide-de-Camp to the Maritime Commander Australia.

In 1998 LCDR Jackman transferred to the Navy Reserve after having her second child, returning to active service in 2001 at Navy HQ as Manager Navy Programs and Events. This saw her responsible to the Deputy Chief of Navy for the coordination for all high level Navy ceremonial events and the management of the Navy involvement in the ADF Parliamentary Program.

2006 saw the Jackman family move to Adelaide and in 2009 LCDR Jackman became the first female CEO of the Returned and Services League (RSL) South Australia. Since that time she has embarked on the task of modernising the business practices and updating the image of the RSL.

Catherine Mahoney served as an Intelligence Officer in the Royal Australian Air Force, leaving the Permanent force in 2010. Catherine joined ADFA as a 16 year old officer cadet and subsequently enjoyed a variety of tactical and strategic postings. Highlights included deployments on Operations Relex, Catalyst and Slipper in support of maritime patrol aircraft operations; Aide-de-Camp to the Governor-General; and 12 months Arabic language training, where Catherine met her husband, Michael.

Catherine has subsequently commenced a varied and interesting career in the Australian Public Service across the Departments of Defence and Veterans' Affairs. Catherine has a post-graduate qualification in human resource management and has almost completed a Juris Doctor. Recreational interests include walking around the Lake Burley-Griffin with Michael and Cooper (the family dog) and planning the next travel adventure.

Anne Pahl joined the Royal Australian Navy in 1988 and saw Operational service on the HMAS Jervis Bay as part of Operation Solace in Somalia during 1992-93. In 1999, she transferred to the RAN Active Reserve as Chief Petty Officer with the Defence Force School of Signals Maritime Wing at HMAS Cerberus.

Anne actively represents the interests of veterans, particularly younger veterans and current ADF serving Members. Since 2008, she has been a Member of the Prime Minister's Advisory Council on Ex-Service Matters. Anne is a board Member of the Victorian RSL State Executive, is the RSL National Representative on the DVA Emerging Issues Forum, chair of the Victorian State RSL Young Veterans Forum, and chair of the Victorian State RSL Veterans' Affairs Aged Care Consultative Committee. Anne is also a Member of the Heidelberg Repatriation Veterans Centre / Veterans Psych Unit Project. Anne is married to a serving Chief Petty Officer Bosun who is currently posted to NU-Ship Canberra, and they have two children, Stephanie (14) and William (9).

Julie Blackburn is a registered nurse and midwife, and has been the National Convenor of Defence Families of Australia since January 2010. DFA is a volunteer based organisation that advocates for Defence families and works with the Australian Government and the Department of Defence to ensure family friendly policies and conditions of service. She is also a Member the Prime Minister's Advisory Council on Ex-Service Matters.

Appendix B

Information sources

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Guest Presenters

- Dr Samantha Crompvoets, Research Fellow, ANU College of Medicine, Biology and Environment
- Judy Daniel, First Assistant Secretary Health and Community Services Division DVA
- Neil Bayles, A/g First Assistant Secretary Rehabilitation and Support Division DVA
- Letitia Hope, Assistant Secretary Primary Health Care Policy Branch, DVA
- Jim Porteous, Director Rehabilitation and Compensation, Joint Health Command, Department of Defence
- Mike Armitage, Director Rehabilitation, External Liaison and Communication, DVA
- Captain Sarah Sharkey, Director of Health Service Delivery, Joint Health Command, Department of Defence
- Air Commodore Steve Martin AM, Joint Program Manager (Defence), Support for Wounded, Injured or Ill Program (SWIIP)
- Matthew Cartledge, Director Service Development Section, DVA
- Wendy Addison, Assistant Director Transition Support Services, Defence
- Cathy Davis, Director National Operations, Defence Family Helpline, Defence Community Organisation
- Eiloea Scriven, DVA On Base Advisor
- Associate Professor Susan Neuhaus CSC
- David Morton, Director General Mental Health Psychology and Rehabilitation, Joint Health Command, Defence
- Christine Reed, Acting Director Mental Health Policy Section, DVA
- Dr Stephanie Hodson CSC, DVA Mental Health Advisor

Appendix C

Overview of recommendations from *The health and wellbeing of female Vietnam and contemporary veterans* report

Overview of recommendations

1. **Develop targeted support and resources for female veterans**
2. **Increase the visibility of services for and experiences of female veterans**
3. **Facilitate continuity of learned coping strategies post-discharge from the ADF**
4. **Implement and evaluate family friendly practices**
5. **Provide training to civilian health care providers on issues for female veterans**
6. **Develop best practice guidelines for the treatment of female veterans**
7. **Set a strategic research agenda on female veterans health**

Appendix D

List of Abbreviations and Acronyms

A-SWIIP	Army Support for Wounded, Injured or Ill Program
AAT	Administrative Appeals Tribunal
ADF	Australian Defence Force
ADFRP	Australian Defence Force Rehabilitation Program
AO	Officer of the Order of Australia
Army	The Australian Army
ARP	Applied Research Program
CAP	Crisis Assistance Program
CFTS	Continuous Full Time Service
CSC	Conspicuous Service Cross
CSM	Conspicuous Service Medal
CTAS	Career Transition Assistance Scheme
DART	Defence Abuse Response Taskforce
DCO	Defence Community Organisation
DDEC	Defence/DVA Executive Committee
Defence	The Department of Defence
DFA	Defence Families Australia
DLSC	DVA/Defence Links Steering Committee
DVA	The Department of Veterans' Affairs
ESO	Ex-Service Organisation
GP	General Practitioner
HQ	Headquarters
JHC	Joint Health Command
MEAO	Middle East Area of Operations
MECRB	Medical Employment Classification Review Board
MBHS	Medibank Health Solutions
MoU	Memorandum of Understanding
MRCA	Military Rehabilitation and Compensation Act 2004
OBAS	On Base Advisory Service
PT	Physical Training
PTI	Physical Training Instructor
PTSD	Post Traumatic Stress Disorder
RAAF	The Royal Australian Air Force

RAN	The Royal Australian Navy
RPBS	Repatriation Pharmaceutical Benefits Scheme
RMA	Repatriation Medical Authority
RSL	Returned and Services League
SeMPRO	Sexual Misconduct Prevention and Response Office
SoPs	Statements of Principles
SRCA	Safety, Rehabilitation and Compensation Act 1988
SWIIP	Support for Wounded, Injured or Ill Program
UNTAET	United Nations Transitional Administration
VAN	Veterans' Access Network
VEA	Veterans' Entitlements Act 1986
VRB	Veterans' Review Board
VVCS	Veterans and Veterans Families Counselling Service