The Effect of the Civilian Transition Experience on the Health and Resilience of Younger Veterans

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EXECUTIVE SUMMARY:

This study generates insights into the experiences of younger veterans’ physical, social and cultural environments and their health, resilience and mobility patterns when transitioning into civilian life. It makes a significant contribution to our understanding of the appropriate interventions necessary to assist individual veterans to pro-actively maintain physical and mental resilience in place and achieve a strong sense of wellbeing with their family and community support network. A veteran who does not successfully deal with their physiological and emotional responses to civilian transition is more prone to serious physical and psychological illness. For the individual veteran it is a process of complexity and change in their ‘sense of place’, their identity and interaction with their local community.

Analysis in this study concludes that younger veteran health resilience and wellbeing can result from a sense of belonging to the economic, social and cultural processes in place. Pro-active outreach social network programs ‘bond’ younger veterans and their support network within the veteran community and provide a bridge to other communities and institutional networks. Analysis of younger veterans’ experience in the Ryde Local Government Area (LGA) community indicate the institutional and community arms of intervention and support structures has not stretched, protected or fostered their veteran resilience, thereby exacerbating negative health responses and poor wellbeing.

The health resilience survey instrument developed in the research, gives conceptual insights as to the effectiveness of interventions, rehabilitation programs and other pathways to medical and psycho-social care provided by the state, institutions and services. This survey will provide the basis for further nationwide research on the dynamics of civilian transition for younger veterans. An innovative outcome from this study will be a Health Resilience Index that will provide a more informed and effective intervention policy.
PROJECT DETAILS:

Project Title: The Effect of the Civilian Transition Experience on the Health and Resilience of Younger Veterans

Aims of the Project:

The aim of this research was to conduct a two phase pilot study on younger veterans (aged 18-45 years) (Wave 4) to understand the role of the veteran’s support network and its effect on the health resilience and wellbeing of younger veterans undergoing transition to civilian life. This project is important because it is innovative in giving understanding in the following ways:

• Provide knowledge of the dynamics of economic, health, social and cultural change through the localised everyday life of younger veterans in Ryde adapting to civilian life.
• Insight as to the relative importance of personal attributes, local places, community and the Returned & Services League of Australia (RSL) and Department of Veterans’ Affairs (DVA) institutional support in a theoretical framework for understanding resilience.
• Comprehension of the mental and physical health symptoms and economic, social, cultural and health functioning in Australian younger veterans returning from deployment in Iraq and Afghanistan.
• Perception as to whether the DVA and RSL’s formal and informal organisational structures contribute to exclusion and resistance and are directly responsible for producing health inequality and status.
• Provide the basis for the development of a Health Resilience Index that will inform policy formulation and implementation to assist veterans.

Benefits and Significance:

This project examined the risks and problems of younger veterans and endeavoured to give awareness as to what is also required to assist interventions in their support network environment. Interventions intended to increase resilience and enhance treatment for younger veterans until now has concentrated on the veterans only but previous research by the Chief Investigator (CI) has shown the support network need those resources as well if resilience and treatment is to be enhanced (Greenwood, 2011). Economic, social and cultural support, family functioning, and occupational satisfaction (Boscarino, 1995), which depends on many individual factors such as ‘personal expectations, subjective perceptions and causal attributions of occupational success and failure’ (Weinert & Hany, 2000:73), are important components of a support network. Combat veterans who have high levels of social support are at less risk of experiencing depression, trauma-related problems, and suicide after a combat experience than peers who have inadequate social resources and conflict in their support network (Boscarino, 1995). Closeness to family members also enhances military members’ resilience after traumatic combat-related experiences (Mills et al, 2011).

This study makes a significant contribution to our understanding of the appropriate interventions necessary to assist veterans in adapting from the ADF to civilian life and achieve a strong sense of wellbeing and belonging in their support network. The health resilience survey instrument developed in Phase 2 of the research recognises the effectiveness of interventions and the emerging health issues and concerns of younger veterans. This survey will provide the basis for further nationwide research on the dynamics of economic, health, social and cultural change.
through the everyday life of younger veterans transitioning in their local environment. An innovative outcome from this study will be a Health Resilience Index that will provide a more informed and effective intervention policy.

DESCRIPTION OF PROJECT:

Research Focus:

This research aims to conduct a two phase pilot study on younger veterans (aged 18-45 years) to understand the role of the veteran’s support network and its effect on the health resilience and wellbeing of younger veterans undergoing transition to civilian life.

Team: Dr Verity Greenwood (Chief Investigator)

Governance: Macquarie- Ryde Futures Partnership Grant

Methodology:

The research utilised two phases of quantitative and qualitative analysis within a conceptual framework. In Phase 1 this framework incorporated and built upon the existing theoretical framework relating to health resilience (Greenwood, 2011). This framework was further developed and based on interviews and focus groups in Phase 1. The themes that emerged from interviews and focus groups informed and validated the framework which incorporated analysis of key relationships between individual and area characteristics. An interdisciplinary approach aimed to capture and untap the physiological, emotional and behavioural responses of younger veterans to their transition experience. It allowed in-depth analyses of key factors and concerns within interrelated themes which included transition, health resilience, informal/formal social capital, care and community.

Phase 2 drew on the qualitative data obtained in Phase 1 to develop and build on the existing Health Resilience survey instrument designed and successfully used in previous research (Greenwood, 2011). This survey was distributed to younger veteran members with a particular focus on those who presently or previously resided in Ryde. It had an inclusive approach to the veteran individuals and health resilience, so allowing individuality in responses for those that do not fit into an existing system or structure, so that effects of overlapping vulnerabilities are not masked.

The qualitative and quantitative data and methods used to enunciate and scrutinise suppositions, significance, alternatives and diversity are presented in each stage of this study. The following sub-headings address the principal steps involved in the research methodology as illustrated in Table 1 (see Table 1).

Ethics and Participant Recruitment: March – July 2014

Following ethics approval, recruiting prospective veteran participants for the in-depth interviews and focus groups was generously facilitated by Tobruk House, North Bondi RSL sub-branch. Phase 1 began with a webpage invitation promoted by Tobruk House, requesting its younger veteran members to nominate to participate in the research, as an interviewee, either in a focus group and/or a personal in-depth interview.
Final number of personal interviews were determined by time, geographical location and veteran health and preferences. All respondees to the invitation opted for a personal interview. 28 personal interviews were conducted with Wave 4 younger veterans and three personal interviews were conducted with executives from Ryde Ex-Services Memorial Club, Ryde, Gladesville RSL & Community Club and Ingleburn RSL sub-branch. Two focus groups were conducted with Tobruk House (2 participants) and North Ryde RSL executive (3 participants). To further clarify background and emerging data relating to veteran access to health and services, a personal interview was conducted with the Manager, Veteran Centre, Northern Beaches and discussions were held with the Welfare Officers’ Forum and Pension Officers’ group attached to that centre. A further personal interview was conducted with an executive with Soldier On, a veteran organisation, and one focus group was conducted with RSL Defencecare (3 participants), a non-profit organisation that assists veterans with entitlements, advocacy and well-being. Throughout the interview period the CI was able to conduct participant observation and networking opportunities through invitations to veteran events, forums, workshops and meetings.

The personal interviews and focus groups gave a good understanding of the range of health problems and risks confronting these veterans in their home environment. Phase 1 was designed to gauge interrelated themes underlying the research, particularly the needs of young veterans in transition in their ‘micro’ local areas, whilst protecting veterans from undue psychological stress. The aim of Phase 1 was to inform and develop the health resilience survey utilized with Ryde LGA younger veterans in Phase 2 and the comments and views of all the interview participants were taken into account in finalising the survey questionnaire.

**Interviews and Focus Groups - July – November 2014**
Veteran interviews were conducted in informal semi-structured conversational format in socially relaxed settings, approximately 60 minutes in length. In dealing with sensitive issues emotional and physical comfort was paramount and option of place for interview/focus groups left to participants, with most veterans choosing a location away from their home and/or workplace environment. A consent form and verbal advice described participants’ rights in the conducting, recording and transcribing of the interviews/focus groups. Participants were guaranteed anonymity and confidentiality and advised that they will be protected by pseudonyms with relationships and events disguised. NVivo 7 was used to manage and analyse gathered qualitative data.

**Health Resilience Survey: Ethics Process**
*Phase 2 used the health resilience survey built on the interviews/focus groups in Phase 1. The survey was designed as an easy to complete mail-based self-administered questionnaire. The aims of this survey were: first, to seek demographic information about the participants; second, to identify those participants who changed residence after becoming a veteran and the reasons for doing so; third to determine the general health levels of participants, their access to medical resources, their community support, behaviour and lifestyle and fourth, to understand attitudes and support factors that either enhance or negate the participant’s relationships with their community, the Department of Veteran Affairs (DVA) and veteran organisations.*

The general principles seen as fundamental to a good self-report measurement process (Fowler, 1998) were followed. The majority of questions required only a tick while a small proportion require one line answers. The survey was contained in a single yellow booklet to draw attention to its presence and act as a reminder and designed to be completed within 30 minutes. The first
section of the survey included socio-demographic questions asking participants about their age, sex, year of becoming a defence force veteran, present marital status, travel behaviour, source and status of income, household composition and tenure, residential relocations and the reasons for them.

The second section focused on health. It included self rating of health status, contacts with health professionals, health problems, leisure-time physical activity levels and health behaviours. Incorporated in this section is a self report Difficulties Questionnaire (DQ) where 19 items can be marked “Not True”, “Somewhat True” or “Certainly True”. In the third section, veterans were asked to identify their level of social capital, particularly their local and extended civic participation and social networks.

The final section concentrated on experiences as a veteran and included questions about community and individual attitudes and any exclusionary practices towards the participant as a veteran as well as the veteran’s bonding and bridging ties within their community, with the DVA and veteran organisations and their resources. There were open-ended questions within each section of the survey form. Information from all respondents was used in the current analyses.

**Health Resilience Survey: January- June 2015**

In Phase 2, to ensure the pilot survey instrument provided a means of obtaining the best possible data, the survey was planned to be distributed to 50 younger veteran members of the North Ryde RSL, aged between 18 and 45 years. Unfortunately North Ryde RSL was unable to assist as they only had one active veteran member within the study criteria. Ryde Ex-Servicemen’s Club also had only one active younger veteran member and Gladesville RSL & Community Club had no active younger veteran members. Following extensive negotiations, recruitment of younger veteran members was facilitated with the pilot questionnaire.

The pilot survey was sent to 50 veterans who met the age criteria, with a particular focus on those that live or have lived in the Ryde LGA. Included in the survey package was a covering letter, pre-paid envelope addressed to the veteran participant and the survey itself. The nature of the survey was exploratory as the individual characteristics, status and location of most of this veteran population was unknown to the researcher.

**Regional Context Analysis: July – November 2015**

A quantitative analysis of statistical data was undertaken to provide a community profile study of each participant and indicate as to how particular places and spaces affect a veteran’s ‘sense of place’ and their identity, attachment, boundaries and interactions with their community and support network. Mapping responses as experience can be affected by the veteran’s everyday environment, health resources and support network. Anonymity in coding and mapping ensured confidentiality for each participant. This research indicated the relevance of correlating demographic census data, obtained from Australian Bureau of Statistics (ABS), in one suburb/region to another. The Local Government Area (LGA) unit was used.

**Statistical Analysis of Survey Data –July – September 2015**

Data was entered into Excel spreadsheets, and descriptive coded statistics, frequency values and percentages performed in the Statistical Package for the Social Sciences for Windows (SPSS).
RESEARCH FINDINGS:

In July, 2013 the Department of Veterans’ Affairs (DVA) implemented a new strategic research model with a number of key issues, including the DVA’s Applied Research Program, to generate best practice research about the health and well being needs of Australia’s veterans, ways to improve DVA’s services and care and support for the DVA to respond effectively to emerging issues facing the veteran community (DVA, 2013). Two particular DVA research domains pertinent to this study include a focus on Families, being the physical and emotional wellbeing of the families of veterans and former ex-serving members and Interventions, to identify trends, determine best practice and measure effectiveness of interventions (DVA, 2014a).

There are three sets of legislation available to younger veterans for rehabilitation and compensation in the event of a physical or mental injury. The Military Rehabilitation and Compensation Act (MRCA) is for members of the ADF, including Permanent Forces, Reserve Forces, Cadets and officers, ADF Honorary rank or appointment and accredited representatives of a registered charity who perform acts at the request of direction of the ADF, persons receiving assistance under the Career Transition Scheme and others declared to be members of the ADF by the Minister of Defence (DVA, 2014b; 2015a).

The Safety, Rehabilitation and Compensation Act (SRCA) covers operational service between 7
April 1994 and 30 June 2004 and peacetime and peacekeeping service up to and including 30 June 2004 (DVA, 2014c;2015a). The Veterans’ Entitlements Act (VEA) covers service 1972-2004 (DVA, 2014d) and s. 5C of that Act defines a veteran as meaning a person who:

- has rendered ‘eligible war service’;
- was a member of the Australian armed services forces who, after 31 July 1962, was engaged in warlike operations against hostile forces outside Australia but not on ‘operational service’ in an operational area and was injured, contracted a disease or died due to action of hostile forces; or
- is a ‘Commonwealth veteran’, ‘allied veteran’ or ‘allied mariner’ (for service pension, Repatriation Pharmaceutical Benefits Card and Commonwealth Seniors Health Card purposes only).

‘Eligible war service’ is defined in s.7 of the VEA and includes:

- ‘operational service’;
- continuous full-time service (CFTS) in the Australian armed services in World War I;
- CFTS in World War II in the Australian armed services (enlistment before 1 July 1947);
- CFTS service as a member of the Australian Interim Forces after 1 July 1947; and
- service in World War II by Australian mariners.

‘Operational service’ is defined in ss.6A–F of the VEA and is in effect a subset of eligible war service.

A number of veteran organisations assist veterans undergoing transition to civilian life. The Veterans and Veteran Families Counselling Service (VVCS) provides free confidential counselling and support for war and service related mental health conditions and relationship /family matters. There are four branches in the Sydney Metropolitan Region (SMR), being Sydney CBD, Parramatta, Liverpool and Northern Beaches. The latter three are outpost centres with limited hours of operation. VVCS has a ‘Stepping Out Program’ to assist transition from the ADF to civilian life (VVCS, 2015).

Defencecare assists current and ex-serving men and women in the ADF and their families in times of injuries, illness and crisis. Their services are grouped into three main areas, pensions advice, advocacy and community support. Located in the Sydney CBD, Defencecare Advisors provide advice one day a week at Holsworthy, HMAS Kuttabul, Potts Point, Sydney and Williamstown.

Mates4Mates provides holistic physical and psychological rehabilitation programs for veterans and their families (Centres in Brisbane, Townsville and Hobart). Soldier On is a not for profit organisation, which is independent of the RSL and DVA, that supports physically and psychologically wounded veterans to ‘enhance recovery, inspire communities and empower Australia’s wounded’ (Soldier On (2014); Talbot (2014)) (Centres Canberra, Adelaide and Concord West). Young Diggers provides a variety of support services and programs to help serving and ex-serving personnel of the ADF, their dependents and direct family members (Based in Queensland-staffed by volunteers) (Young Diggers, 2015).

Two Veteran Centres have recently opened in the Sydney Metropolitan region (SMR). On the 5th December, 2014 the North Bondi RSL sub-branch opened the RSL Veteran’s Centre East Sydney, Bondi Junction. This Advocacy Centre for veterans is supported by Waverley Council.
and the opening was attended by DVA personnel, the NSW Governor and senior military personnel. At the opening the Minister for Veterans’ Affairs noted the necessity of such a centre to the veteran community and the DVA’s acknowledgment that younger veterans and their families need assistance to readjust following deployment (Senator Ronaldson, 2014). This centre provides welfare and advocacy services for veterans and serving members and

‘…offer assistance to those wounded on operations, … provide comfort parcels to those on duty around the world, provide pro bono entitlement advisors and advocates to assist with entitlement claims and provide mechanisms to support those who are doing it tough. “Mates helping mates” (Tobruk House, 2014)

More recently, The Veterans Centre, Sydney Northern Beaches opened on the 16th October, 2015 to operate from an office within the Dee Why RSL. At the opening it was noted that the Veteran centre was timely as 25 Australian veterans had suicided in 2015, representing approximately 10 percent of Australian veteran suicides since 1990 (Bishop, 2015). Covering the Northern Beaches region, and soon to extend to North Sydney, the Centre is supported by a DVA financial grant for the provision of Pension and Welfare services, sponsorship from Dee Why RSL Club and assistance from Macquarie University Participations and Community Engagement (PACE) program. Using a ‘hub and spoke’ model, the hub being the Veterans Centre and the spokes being the individual welfare and pension groups within the region, this Centre has developed a Case Management Response system which is being incorporated across the region to enhance proactive and reactive responses to veteran health and concerns.

**Phase 1** of this research addresses two of its research objectives. First, to comprehend the mental and physical health symptoms and economic, social, cultural and health functioning in Australian younger veterans returning from deployment in Iraq and Afghanistan and second, to gain insight as to the relative importance of personal attributes, local places, community, technologies and the RSL and DVA institutional support in a theoretical framework for understanding resilience. These two objectives also fit into the DVA’s Families and Interventions research domains.

Tobruk House, North Bondi RSL sub-branch was the conduit for Phase 1 in this research. Overlooking the northern edge of Bondi Beach, Tobruk House is situated within Waverley LGA at a distance of 10 kilometres east from Sydney Central Business District (CBD). With a population of 10,629 (ABS, 2011a), Bondi Beach is an established tourist destination. which varies in its residential, commercial and institutional mix to form a diverse commercial, social and cultural environment. Founded in 1944, Tobruk House has a current membership of 700 veterans including:

‘...members that are in Queensland, Victoria and the ACT. We've always been of the mindset here that if you're a member here and you transfer out of state, you can either transfer your membership, or you can keep it here. Or if you transfer out and you don't like where you're at, you can always re-join here, transfer back into here. We will look after our members to the best of our capabilities, even if they're interstate’ (Tobruk House welfare staff member).
North Bondi RSL sub-branch is situated in an idyllic setting but the main reason its membership is so strong is due to its pro-active stance in reaching out to its veteran members, in providing advocacy, ongoing counselling and welfare support to veteran families, in utilising the natural environment and its location for events that are inclusive for veterans and their families and importantly, working in tandem with support from Waverley Council. Examples of the welfare work undertaken for veterans include:

- Post-deployment assistance
- Resume/CV writing services, job placement and retraining for transitioning from the ADF into civilian life
- Hospital, rehabilitation centre and nursing home visits
- Supporting defence force children (including award ceremonies to award and recognize children of serving ADF members)
- Suicide prevention and referrals to counselling
- Assistance to killed-in-action soldier’s families
- Direct welfare support to an active army regiment
- Sports and recreation programs to aid in physical and mental wellbeing
- Service Stories- promotion of public speaking to assist in overcoming anxieties
- Fighting veterans Homelessness (Keogh, 2014)

Manned by both permanent and volunteer staff, there is a secret to attracting and retaining younger veterans:

'We try to create and continue engagement with our members. We maintain a website and social media so we stay in contact with our younger members. We also send out newsletters to our older members. Our role is quite varied, we do lots of admin stuff, but then deal with the members, members' services and things like that. We try to look for events and activities that can engage our members and want them to be involved, so they come and see us and be active participants in the sub-branch. That's working with the younger people especially, but the older guys we've made quite a rapport with too. So it's nice, we get a good balance' (Tobruk House volunteer executive member).

The Anzac Day service has grown in numbers and in 2015 attracted thousands of attendees, including VIPs, veterans, their families and the community. Each Service has a specific Veteran theme followed by an Anzac breakfast for veterans, members and their families. Tobruk House also has an ongoing link with a unit at Holsworthy and have developed a good rapport with the senior staff in that unit.

'It's important to say that we’re lucky with the guys out at Holsworthy. The adjutant is really good at keeping those lines of communication open and working at that cross point where people are coming out of Defence and coming into society, where we can really help people' (volunteer Advocacy officer, Tobruk House).

Interview Results

As stated previously, 28 Tobruk House younger veteran members accepted the invitation to be interviewed, with five of those interviewed being residents of Ryde LGA. To ensure anonymity and confidentiality for each interview participant, references to age and residential location are not specified in any quotes given in this section.

Demographic and socio-economic characteristics
All interviewees were male, aged between 25-40 years and had been on active deployment overseas, with a number being deployed multiple times. Their level of service and rank varied, but the majority of interviewees’ service was in the Commandos, a specialised high risk unit. Being in the Commandos appears to make a difference in supporting the civilian transition experience. The following veteran sums up the experience of the Commando veterans interviewed:

‘Say if I had have been in an infantry regiment and I was discharged, then that support wouldn't have been there. But because I was part of the Commandos, they tend to try their utmost to look after you. It falls down in most cases but they do try and make the connections and make sure you're on your path.’

The majority of the study sample were divorced or separated (72%) whilst a small minority were married (12%) or single (16%). The pressures on family life when an ADF is on deployment overseas can contribute to marriage breakdown on their transition to civilian life:

‘My son - I was in Iraq when my son was born. That's the way it was. Because I had no other children, the way that Defence looked at it - if I had another child, I would've been home for that birth because someone has got to look after that child, but because there's no one else to look after, they say see you later. Now, did the fact that I was away contribute to my divorce or something like that? Maybe, maybe not. But I was married for eight years and I spent six of them at sea. That's hard. Two people grow apart, they go that way. I wasn't there, and I wasn't allowed to argue the point that my son or my family or my marriage was actually important. It just wasn't a factor at all. Now I’m back and the marriage has broken up, being a civilian has certainly thrown its fair share of curveballs at me.’

Level of education was based on years of completed education with the majority reporting completion of the Higher School Certificate. Moreover, 14 percent were employed fulltime in corporate employment and 86 percent were unable to work due to health and were receiving or in the process of applying for benefits under the MRCA. Of this latter group 7% were engaged in volunteer part-time employment.

An overwhelming majority rented their property (93%), lived independently alone (82%) in a unit (93%). The majority of all age groups lived in the Sydney Metropolitan area (93%) whilst the same percentage moved from their pre-veteran address after re-entering civilian life. Reason/s for moving place of residence included homelessness following separation from partner (54%), moving nearer to the Sydney CBD (28%) and moving from the family home (18%).

**Health, morbidity and health-care utilisation**

Of those who self rated their health as ‘excellent’ nearly all judged their overall physical health (82%) to be ‘good’. Depression and Post Traumatic Stress Disorder (PTSD) (89%) were the highest reported health problems, followed by joint injury (54%). The group significantly consulted general practitioners on a regular basis, with trust of the family doctor dictating usual place of health care. Frequency of health visits may also be affected by transport options and there is an association between place of residence and mode of transport used with 86 percent of participants using public transport as their main form of transport followed by the car (14%).
Poor physical or mental health kept 84 percent of the participants from doing their usual activities for at least one day in a month. Among the participants the majority have difficulty sleeping (93%) compared to pre-veteran status. A number of participants found difficulty in going solo on social outings (82%). One veteran explains:

‘I just sit like a stunned mullet on my lounge. I can’t even be bothered watching TV. I’ve attempted suicide three times and the last time I tried to do it in front of my ex-wife. Now she has an AVO out against me so I can’t see my kids unless I have supervised visits. They live in Wollongong. So I have to go by bus and train down there and try to see the kids with someone watching me all the time. Everything is hopeless.’

**Lifestyle/ Behaviours**

The most frequently reported physical activities were moderate (78%), much higher than relaxation pursuits (14%), with only 8% indulging in activities of a social nature. All saw their activities as falling short of their activity level prior to being a veteran. Despite the relatively low rate of engaging in activity over the past three months among the veteran participants, all of the activities were nevertheless associated with community engagement.

All data is self-reported and the possibility of reporting bias, especially for smoking and alcohol intake, cannot be dismissed. Only 14 percent was currently smoking one or more cigarettes daily and of this group all smoke one or more packs a day. Others turned to substance abuse:

‘When I was in the Army Reserve I actually developed a substance abuse problem. I was smoking a lot of marijuana. After years of being in the army and the bullying and stuff I just developed a habit out of it. I guess I was using that as a form of escapism. I never went to work stoned or anything like that. It was always after course or after work or anything like that. It got worse as the bullying got worse and I ended up smoking probably $50 worth a day, which was probably three grams. I think that's a fairly heavy habit that I am now going to try and get out of.’

In contrast, all of the participants drink alcohol, with the majority admitting they consume too much. The mean number of alcoholic drinks consumed in one day is five and most drink when alone and /or depressed (86%). The following veterans explain:

‘Before I left on deployment overseas, I drank socially. We were dry overseas. When I came back I drank alone. When I drink it lowers my inhibitions. I don't know, I just think I got into a habit. Didn’t really have a purpose to it, I just ended up doing it a lot. When I was bored or when I was lonely, I just drank. Being on the computer or watching TV, drinking. It just became a habit.’

‘I've been drunk because I've been upset or lonely, many a time. If it wasn't for my son now, I'd probably be in a box. If you want to get fair dinkum about this stuff, honest to god, I'd be in a box. My father knows it, my mother knows it.’

**Social networks**

The veterans were generally satisfied with attitudes in their community since becoming a veteran. The degree of trust and extent of social networks was addressed directly by several questions in the interviews. Trust was generally family and friend focused, with a general trust in people. Institutional trust was mixed with 75 percent of the veterans group not having confidence in the legal system, government, banks and corporations. Approximately a third do not trust either the health system or welfare system. An overwhelming majority do not have trust in the DVA (93%). Sharp and significant differences exist in the size of the family and neighbourhood networks and the total number of persons with whom a close emotionally important and
supportive relationship is maintained. Renewing relationships with family and friends in transition can be difficult:

‘I mean, I guess the main difficulties I had with getting back close to my family and friends was, nobody really understood what it was that we did, and no-one was really that interested, to be honest. It was quite rare that people actually were interested.’

Veteran Transition Experience
The majority of participants believed their civilian transition experience depended strongly on the support received whilst on overseas deployment. One veteran recalls:

‘We were out in the field when my best mate stood on a mine and got blown up beside me. There was no time to let out our emotions, we just had to clean everything up and continue what we were doing, as if nothing had happened. When we got back to camp, our warrant officer, who was also assigned as my supervisor, not a good thing, told us not to get ‘pink and fluffy’ but be men and get out and do our job.’

The mandatory transition program when leaving the ADF was viewed by all interviewed veterans as not assisting their return to civilian life. The majority of veterans had the following similar comments:

‘Yes we have a transition program that we attend before we get into our civvies. They rattled on, I didn’t listen, my eyes glazed over, it was boring and nothing I could relate to.’

‘I went to a day’s presentation that spoke about writing a CV or something like that, and that was about it. I can’t recall anything else from that day because that’s how important it actually was and that’s how I thought of the day.’

All veterans interviewed stated they lied on their psychological assessment forms when they returned from deployment. Reasons included their concern over retaining their military employment and the effect any adverse statement may have on future civilian employment.

Veteran interviewees described their sense of loss on becoming a civilian. The following four veterans sum up the effect that the majority of the interviewees expressed as to this loss:

‘When we were on deployment it was hard going, I can’t explain how hard but it also felt good. We felt a responsibility towards each other, there was a bond between us, an unspoken bond but it was there. And what we were doing was important. Then when we came home suddenly there was nothing. The responsibility was gone. Suddenly we were nothing, not important, nobodies. We all went our separate ways. Some mates I haven’t seen again. Life became empty, the everyday things didn’t matter any more. I would go back tomorrow if I could.’

‘Lack of purpose was difficult, because you had very clear-cut responsibilities. If you stuffed up people died. It was a very good motivator for working long hours, and I really enjoyed it. So coming back, most of the jobs that I did was very much like, what’s the point, why do we need to do this? So it’s changed my perspective on things life-wise as well. I was a very different person when I came back in the aspect that I basically saw a lot of young people can die really quickly, particularly in Iraq, and that made me appreciate things a lot more and made me more willing to go and do things, active things, and live life basically. So that changed quite a bit.’
'Before I left the army, a lot of my friends over the years were constantly telling me to quit the army, I cut them loose, because I love the army. It was - even though it was only Reservists, it was the longest job I've ever had. When I left the army it was like I've got nowhere to go.'

'But what generally happens is guys and girls just want to break away. No, I've had enough; this is in my past. But it never really is, it's still very much a part of you. But the hand was forced. I was medically discharged. So I wasn't leaving of my own accord. They made the decision for me.'

For an interim period the sense of loss may be lifted when a veteran is given the opportunity by a veteran organisation to go on an extended event with other veterans. However any relief is often temporary:

'I got picked to do the Kokoda Track. Some of my old vet mates were there. It was good getting back into the rough of it, walking hard, it made you forget what was back home. But when you get home you crash and you go through everything you first went through again. My wife had enough of it, she said she couldn't put up with it again and she kicked me out.'

Veteran confidence and self esteem is boosted when a veteran takes on a volunteer role within their community or veteran organisation. Volunteerism promotes a sense of belonging to a community, its intrinsic reciprocity character and nature provides benefits that far overcome the disabilities being a transitioning veteran can produce. These veterans enjoyed such benefits:

'North Bondi RSL have programmes like Service Stories. They teach veterans how to improve their public speaking and presentation and to get out into the community and share their voice, which I think raises the profile of veterans but it also improves on their skills.'

'I started volunteering as a lifesaver. The patrol that I'm part of, it's more of a mentoring patrol for young lifesavers coming through. So, you get to talk to young kids about different things to do with life and I find that a good element too.'

'If they want to tackle a real project and really have objectives, outcomes, costings, what are we going to do, how are we going to tackle, I'm more than happy to stick my hand up.'

_DVA/RSL / Veteran Organisation Affiliation_

The majority of the participants have had difficulties in their dealings with the DVA, particularly in submitting their forms under the appropriate set of legislation (SRCA and MRCA). One veteran explains:

'At the moment I'm still going through the fight and the battle is with DVA. I'm only on interim incapacity payments at the moment; I think it's around $600 a week and that's taxable. DVA, they had nothing to do with the accommodation here, that was all from RSL LifeCare. In saying DVA had nothing to do with it, I sent my case coordinator at DVA an e-mail saying that I was homeless asking if they have any crisis accommodation and they had nothing. Then the only person in Vet Affairs that's been actually helpful, she got a hold of these guys here because she knew about the program that they were running. It's not widely known which is a shame.'

Another veteran notes the problems when there is no advocate to assist:

'I filled out my form for the DVA, sent it off then six months later they told me I went under the wrong legislation, the VEA. So I do another form, wait another seven months to be told I did the wrong form again! I've got to put in another form and I now just want to give up!'
'I was medivacced out of the Middle East, I put in my documentation to DVA three times over the past 10 and a bit years and it always gets lost. True story, yeah. No, I give up now. I'm not interested in filling in their 190 pages of bullshit for someone - for it to get lost again. Just not interested, thank you. But what are they going to do anyway, give me $8 a week? Who cares?'

The majority of the veterans felt they 'could have used more support from the DVA than received' (89%). Membership of the North Bondi RSL sub-branch was strongly associated with a small but strong social network. The veterans indicated a positive relationship between North Bondi RSL and veterans, with 'a sense of place', 'belonging' and emotional support 'having some effect of the RSL on the 'sense of belonging' of the veteran.

That same 'sense of place' did not exist for the younger veteran Ryde residents when considering their local RSL branch and sub-branches. There are three RSL options for veterans within the Ryde LGA. North Ryde RSL, Ryde Ex-Servicemen's Club (RydeX) and Gladesville RSL and Community Club. One described their local sub-branch as 'just for beer and bingo' whilst another felt animosity from the Vietnam veterans:

'The divide between us is immense. The Vietnam vets just don't want to know us.'

'There is stuff listed on their website to help veterans but there is not one thing in this club that recognises that vets from Iraq and Afghanistan even exist. When I needed help filling out the DVA bits and pieces, I tried to battle for awhile by myself but in the end I went over to North Bondi after a mate told me how good they were - no help near home.'

'I look at things like RSLs and these pigeonholes of national service guys in Vietnam and they think that they run this and they run that and we've got all these bloody [softies] and when I look at Defence in its entirety, that's why I've got nothing to do with it. I refuse to. It's a mess. Defence is a mess. It's full of clowns. It doesn't offend me that I don't get invited to sub branch meetings. They're nothing but a bunch of spastics that want free cucumber sandwiches and a couple of free beers. But I'm not interested in a free cucumber sandwich, sitting around crying Kumbaya about Vietnam or the Gulf War. I don't care.'

Yet, North Ryde RSL, whose older veteran members has now dwindled to approximately 100, has attempted a number of avenues to draw younger veterans into its membership. There is a total reliance on a small army of volunteer welfare officers to provide counselling and welfare support to older veterans, visiting them in hospital or their homes and providing equipment for their mobility. There are no programs for younger veterans. The Anzac Day service is the Club's big annual event. Approximately 200 attend and march. Older veterans attend the Service but are diminishing in numbers. A Ryde RSL executive reflects:

'Well, the veterans are less but the crowds are more, with about 200 marchers. One of the reasons is we visit about 14 schools prior to Anzac Day. All the members of the committee go around and make a little speech at the school. See, if we've got a Youth Club here. They're represented. The local scouts and guides are represented. Schools are represented. The oration is given by two children from our local high school, usually the school captains. They're absolutely marvellous. We have the St John Ambulance here in force look after the marchers. The march has been shortened up some. We hold the ceremony at the cenotaph out there. We have the police down who stop the traffic. It's quite a big function. We're very proud of it'.
Survey Results

Phase 2 of this research addresses three research objectives. First, to provide knowledge of the dynamics of economic, health, social and cultural change through the localised everyday life of younger veterans in Ryde adapting to civilian life. Second, to gain insight as to the relative importance of personal attributes, local places, community and the RSL and DVA institutional support in a theoretical framework for understanding resilience and finally, to provide the basis for the development of a Health Resilience Index that will inform policy formulation and implementation to assist veterans.

Phase 2 drew on the qualitative data obtained in Phase 1 to design a pilot Health Resilience survey instrument which was distributed to 50 veterans who met the age criteria, with special notice taken of those who live or have lived in the Ryde LGA. Located 13 kilometres north-west of Sydney CBD, with a population of 103,038 and a median age of 36 (ABS, 2011b), Ryde is divided into three wards, East, Central and West. Half of the population aged 15 years and over are married, 35 percent of the population are single, whilst a small minority are separated (2.1%), divorced (6.4%) and widowed (5.6%).

Residential stability, together with age and family status, influence the characteristics of communities within the region and demand for services and facilities. Even though Ryde LGA is socio-culturally a multifaceted region, with spaces of social disadvantage, it has managed to sustain a level of solidity in its population. Population migration is recognized as being “a major determinant of an area’s age-sex structure and socio-economic characteristics” (Norman, Boyle and Ress, 2005:1). The majority of residents did not move between 2006 and 2011 and less than 10 percent of residents only moved within the region itself (ABS, 2011).

The SEIFA Index of Relative Socio-Economic Disadvantage (IRSD) is derived from attributes such as low income, low educational attainment, high unemployment, jobs in relatively unskilled occupations and variables that reflect disadvantage rather than measure specific aspects of disadvantage. An IRSD value of 1067 for Ryde LGA suggests the region has proportionately less families of low income and less residents with little training and unskilled occupations than Sydney as a whole which has a SEIFA IRSD value of 1019 (ABS, 2011b). However, as Map 1 illustrates, the SEIFA value within Ryde LGA varies in range across its suburbs which confirms SEIFA values are often deceiving as they do not reflect intra-LGA variations in specific aspects of disadvantage (See Map 1).

As previously stated, Ryde LGA has three RSL or Ex-Servicemen’s Clubs but each has minimal membership of younger veterans. North Ryde RSL and Ryde Ex-Servicemen’s Club (RydeX) have one active younger veteran member each and Gladesville RSL & Community Club has no active younger veteran members. Yet Ryde LGA, which falls within the Federal electorate of Bennelong, is home to 1,694 veterans who are in receipt of a pension/allowance from DVA or who are eligible for treatment or pharmaceuticals paid for by the DVA, with a minimum of 58 and maximum of 224 veterans being younger veterans (18-45 years) (See Table 2). Not included in this table are Ryde veteran residents who have not applied for benefits from the DVA and the veteran families and social support network that are also affected by the health and health behaviour of the transitioning veteran. Table 3 compares Bennelong electorate to that of Wentworth (home to North Bondi) and Warringah (includes Dee Why) Federal electorates. It can be seen that DVA veteran numbers are fairly similar in the three Federal electorates (See Table 3).
Map 1: City of Ryde Index of Relative Socio-economic Advantage and Disadvantage, 2011.

Table 2: DVA Clients in Federal Electorate of Bennelong, New South Wales (as at 26.11.14)

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Average Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Total Veterans*</td>
<td>766</td>
<td>72.32</td>
</tr>
<tr>
<td>eligible under the VEA</td>
<td>599</td>
<td>79.77</td>
</tr>
<tr>
<td>eligible under the SRCA **</td>
<td>166</td>
<td>51.03</td>
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<tr>
<td>eligible under the MRCA ***</td>
<td>58</td>
<td>38.33</td>
</tr>
<tr>
<td>Total Dependents</td>
<td>937</td>
<td>84.67</td>
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<tr>
<td>Net Total DVA Clients</td>
<td>1,694</td>
<td>79.05</td>
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<tr>
<td>Disability Pensioners</td>
<td>376</td>
<td>78.29</td>
</tr>
<tr>
<td>Service Pensioners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans</td>
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<tr>
<td>Partners and widows</td>
<td>307</td>
<td>83.07</td>
</tr>
<tr>
<td>VEA Pensioner Population</td>
<td>305</td>
<td>81.22</td>
</tr>
<tr>
<td>Gold Card Holders</td>
<td>1,397</td>
<td>83.06</td>
</tr>
<tr>
<td>Treatment population</td>
<td>1,145</td>
<td>82.83</td>
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</table>

* Only veterans in receipt of DVA benefits under MRCA, SRCA and VEA
** SRCA veterans potentially may fall within veteran study group (18-45 years)
*** MRCA veterans that fall within the study group

Source: Adapted by author from DVA (2015b)
Table 3: Comparison of DVA Clients in Bennelong, Wentworth and Warringah Electorates (as at 26.11.14)

<table>
<thead>
<tr>
<th></th>
<th>Bennelong</th>
<th>Wentworth</th>
<th>Warringah</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net Total Veterans</strong></td>
<td>766</td>
<td>642</td>
<td>856</td>
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<tr>
<td>eligible under the VEA</td>
<td>599</td>
<td>419</td>
<td>673</td>
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<tr>
<td>eligible under the SRCA **</td>
<td>166</td>
<td>210</td>
<td>217</td>
</tr>
<tr>
<td>eligible under the MRCA ***</td>
<td>58</td>
<td>87</td>
<td>70</td>
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<tr>
<td><strong>Total Dependents</strong></td>
<td>937</td>
<td>551</td>
<td>937</td>
</tr>
<tr>
<td><strong>Net Total DVA Clients</strong></td>
<td>1,694</td>
<td>1185</td>
<td>1781</td>
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<tr>
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<td>376</td>
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<td>Service Pensioners</td>
<td>612</td>
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<tr>
<td>Veterans</td>
<td>307</td>
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<td>217</td>
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<tr>
<td>Partners and widows</td>
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<td>213</td>
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<tr>
<td>VEA Pensioner Population</td>
<td>1,397</td>
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<td>Gold Card Holders</td>
<td>955</td>
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<tr>
<td>Treatment population</td>
<td>1,145</td>
<td>881</td>
<td>1349</td>
</tr>
</tbody>
</table>

* Only veterans in receipt of DVA benefits under MRCA, SRCA and VEA
** SRCA veterans potentially may fall within veteran study group (18-45 years)
*** MRCA veterans that fall within the study group

Source: Adapted by author from DVA (2015b)

The survey response rate was very good, with 66 percent of the surveys returned by younger veterans fully completed. Data was entered into Excel spreadsheets, and descriptive coded statistics, frequency values and percentages performed in the SPSS to study the bivariate relationships between health, health behaviours, DVA, RSL and support systems. Comments and views of these younger veterans will be taken into account and refinements made, if required, to finalise the questionnaire. Importantly this pilot study will determine the suitability of the questionnaire, and its appropriateness, in content, quality and quantity, for the needs of the study and further nationwide research.

Upon receipt every survey was personally read and responses noted by the CI. A number of veterans recorded on the survey their thoughts on the DVA, the RSL and their experiences as a veteran or to explain their health behaviour. Underpinning variation in responses to the survey was the significant role of spatial effects in local place, as identified by MacIntyre et al (2002). She suggests that improvements in public health might be achieved by focusing on place as well as the community within that place. Matthews (2005) argues that the ‘resilience’ of a community is related to its ability to access ‘resources’ through social network relations. The International Resilience Project (2007: 1) takes a bipartite approach in stating:

‘A more comprehensive and progressive definition of resilience emphasizes both the individual’s role in creating health and the relational, social and cultural factors that must be present to create that health when facing multiple risks.’
Resilience can be understood as a social construct (Ungar, 2004) and ‘the outcome of negotiations between individuals and their environments to maintain a self-definition as healthy’ (Ungar, 2005:8). Resilience is also

...both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways.' (Resilience Research Centre (2015); See also Ungar, 2005; Ungar, 2012).

Of noteworthy interest was the responses of the majority of the veterans as to the effect place had on their ability to cope, their pattern of migration, changes in health status, community attitudes, health behaviour and lifestyle and accessing health resources and benefits. Some of the survey veteran recipients made contact with the CI to clarify their status and/or potential benefits available to them. There are a number of items and veteran responses of concern that were particular to the Ryde veterans and did not come up with the interviewees attached to North Bondi RSL sub-branch. The following describes these items under relevant categories, with reference to the survey (See Appendix 4). To ensure anonymity and confidentiality for each interview participant, references to specific gender, age and residential location are not specified in any quotes given in this section.

The demographic and socio-economic characteristics

Q. 3 'When did you become a defence force veteran?' Indicated that some veterans were ignorant as to their veteran status, as evidenced in the following written and verbal correspondence:

'I have the most concern with your use of the word "veteran". How do you define "veteran"? The traditional definition is this term denotes that you have deployed on overseas operations however it is unclear when this term applies.'

'While you are deployed on your first deployment you do not consider yourself a veteran even though technically the label is correct. Nor would most Service personnel call themselves a veteran on immediate return home.'

'Question 3 makes no sense to me. When did I become a veteran? Mate, I don't know. I deployed 6 times in total. I don't know when I started considering myself a veteran.'

This misunderstanding as to the term 'veteran' was not apparent in any of the interviews conducted via Tobruk House. In those interviews, and in discussion with veteran organisations, retired military who had been deployed overseas referred to themselves as veterans. There was also reference to retired military who never had overseas deployment and serving military who had never been deployed overseas referring to themselves as veterans. In reference to the VEA (s. 5C) and from my research with veteran organisations, veterans are considered those persons who have served or are serving in the military, particularly but not exclusively those who have had direct exposure to acts of military conflict who may also be referred to as “war veterans”. Hence, one could be a military veteran with just one day of military service. My research has shown that there probably needs to be a differentiation made between 'veteran' and 'war veterans'. Consideration as to whether a person is a 'veteran' can be both an objective and subjective consideration for respondents. This has been a problem for some who never consider themselves a veteran and do not seek the help and potential benefits that would be available to them as a result.
Email correspondence and telephone calls from survey participants indicated there was also confusion as to the meaning of the MRCA, SRCA and VEA:

‘I am not sure what the MRCA means. How do we know what one benefits us?’

‘What does ADF compensation have to do with being a veteran. For example, Q13-15 “when you became a veteran under MRCA did you..?” You must have a compensatable injury to come under MRCA/SRCS/VEA. Are you referring to being injured while on deployment?’

‘Does Q. 12-15 only refer to those who have been injured? I have an injury so do I tick all those boxes? Or do I go straight to Q.16?’

This confusion suggests the survey study participants have not been provided with the opportunity and the capability to access formal support, such as veteran advocacy support services.

74 percent of survey participants have changed from their Ryde LGA address to move to another geographical area since becoming a veteran. The majority of these gave the reason for their move as being due to divorce or separation from a partner (Q.27)

Health, morbidity and health-care utilisation
Overall, a significant proportion of the survey recipients (63%) rated their own health as ‘fair’ or ‘poor’ (Q.28). Depression (81%) and PTSD (86%) were the highest reported diagnosed health problems. The group significantly consulted general practitioners on a regular basis, with access dictating their usual place of health care. The survey showed the majority have difficulty sleeping compared to their pre-veteran status (Q. 58). Among the study population, the ability to care for oneself was not affected but there was overwhelming difficulty in going solo on social outings.

Lifestyle/ Behaviours
Responses to Q.57 indicated the survey respondents was not very active, at least not in terms of the particular activities listed. As all the survey responses is self-reported there is the possibility of reporting bias, especially for smoking and alcohol intake. 26 percent of respondents smoked one or more packs a day. In contrast, all of the respondents drink alcohol, with most drinking when alone (91%), depressed (65%) or feeling lonely (65%).

Social networks
The degree of trust and extent of social networks was addressed directly by several questions in the survey. The majority indicated a general trust in people. Using a trust scale on a 1 (cannot be trusted) to 5 (can be trusted a lot) scale the common response was family and friend focused. Sharp and significant differences exist in the size of the family and neighbourhood networks and the total number of persons with whom a close emotionally important and supportive relationship is maintained. 65 percent of respondents did not trust people in their neighbourhood, with 26 percent not trusting their immediate family. Information assembled on perceived formal and informal support (i.e anyone to ‘help financially’, ‘feel at ease with’, ‘talk about private matters, and can call on for help’) indicates that most respondents see themselves as having a very small number of ‘close’ personal contacts in their neighbourhood, with 52% having less than three close friends. 50 percent of respondents believed they can count on someone to provide help with emotional support whilst 61 percent believed they could use “a lot more” emotional support.
The survey also indicates that institutional trust is mixed in the study population. The majority did not have confidence in the DVA and the response to the RSL was mixed. Only one positive response was given to Q.72 ‘In the past twelve months, have you given any unpaid help’. Volunteerism is difficult for those individuals who suffer ill health, poor mobility, have demographic disparities or have attributes that do not allow them to readjust (Greenwood, 2011). The majority of the participants utilise the internet regularly to communicate with friends within or outside their neighbourhood.

DVA/RSL Veteran Organisation Affiliation

Responses to the individual items Q. 74 - 100 suggest that the survey participants were generally satisfied with attitudes in their community since becoming a veteran although 91 percent felt different as a veteran to other members in the community and 30 percent felt negative attitudes changed their relationships. 61 percent felt they ‘could have used ‘a lot more’ emotional support than received’ since becoming a veteran (Q.82). In response to Q.86 ‘Are you a member of any of the following veteran organisations?”, only the RSL (96%) received a majority response with approximately half (52%) claiming to be active members of a veteran organisation. These memberships were mildly associated with a small social network yet 73 percent of the respondents felt a close personal tie to their veteran organisation.

Conclusion

Multiplicity of place, in constructing, defining, contributing and excluding veterans transitioning to civilian life, affects the health resilience of its veteran residents. This is supported by a significant quantity of data collected for this research. The methodological approach taken in data collection and analysis has been aimed at acquiring knowledge through research in the search to know, discover and develop a health resilience index for veterans in place. Through this process, the research methods utilised provided an excellent and viable means to explore and discover from first-person accounts and narratives the experiences of veterans. Attention to a range of primary and secondary materials, including information obtained through personal interviews and focus groups, reference material and published records, was enhanced by fieldwork as a participant observer and collaborative relationships with veteran organisations.

As a result of this analysis, it is apparent that maintenance or strengthening of health resilience and wellbeing for transitioning veterans to civilian life in their local everyday places relies on the intersection of individual veteran traits, relationship factors, community contexts and cultural factors. Veteran health responses in place indicate post-transition depression and PTSD, the highest reported health problems in the interviewee case studies and survey, which also appears to be a precursor to both serious and minor health problems. Depression and PTSD seems to affect the ability to alter poor lifestyle and behaviour, even when responsibilities demand it.

A firm sense of belonging to their local place and community is vital to a veteran’s wellbeing in their civilian transition. Such a ‘belonging’ opens up the possibility for veterans to be empowered, to have the courage to reach out to others within their local place and take proactive steps to embrace health and reinstate themselves in their community, albeit with a veteran persona. There are limitations to belonging in local place as it is the interplay of individual health factors, family and community support and institutional resources within local place that makes the difference. This study has shown a sense of belonging can be constructed by veteran organisations and local government support. North Bondi RSL sub-branch is a strong example of veteran individuals seeking out a veteran organisation and community that supports both themselves and their families and illustrates care through its advocacy and veteran
programs. The majority of the interviewees in Phase 1 of this research did not live within Waverley LGA but joined North Bondi RSL in order to belong and be supported.

The majority of the participants have had difficulties in their dealings with the DVA, particularly in submitting their forms under the appropriate set of legislation (SRCA and MRCA). This difficulty appears to be exacerbated if the veteran is not an ‘active’ member of a veteran organisation. Phases 1 and 2 of the research showed scales of knowledge and experience of the DVA claim process is dependant on the veteran’s interactions with the social, cultural and advocacy environment provided by veteran organisations. Such an environment is not available in Ryde LGA.

The pilot Veteran Health Resilience survey in Phase 2 indicates that the majority of resident or former residents of Ryde LGA have had difficulties reformulating their relationships in local place and are unable to draw from the virtually non-existent veteran services within their local environment so they could ‘fit’ or be supported in their local place. Survey responses indicated the majority of these respondents are victims of divorce, family breakdown, unhealthy lifestyles and behaviour patterns, which increase poor mental and physical health.

Earlier Phase 1 Ryde interviewees indicated that the neglect of services for veterans in Ryde LGA caused them to circumvent their local community RSL clubs to seek advocacy and emotional assistance at North Bondi RSL. Veteran volunteerism in Ryde LGA was negligible yet volunteerism promotes a sense of belonging to a community, its intrinsic reciprocity character and nature provides benefits that far overcome the disabilities a veteran in civilian transition can produce. A pro-active stance in contributing to the community certainly cements a participant’s belonging, raises their community acceptance and enhances their health resilience in their local place.

RECOMMENDATIONS:

One outcome of the research is the realisation that there is a dearth of support services for younger veterans in the Ryde LGA and surrounding regions. Yet this research indicates it is an absolute priority to assist younger veterans to adapt to their civilian environment and support the family and social network within their community, which can make such a difference to their health, health behaviour and health resilience. The RSL Clubs and sub-branches within the LGA have no pro-active programs that reach out to its younger veteran population and their families. The veteran membership within these clubs is diminishing and ageing and, as a result, focus is on volunteer staff supporting the elderly veterans rather than rethinking new innovative activities to attract and support younger veterans.

**Recommendation 1: Establishment of a veterans’ centre in Ryde LGA.**

It is now timely for a Veterans’ Centre to be established within Ryde LGA. Within the SMR, eastern and northern Sydney veterans now have the services of the RSL Veterans’ Centre, East Sydney and the Veterans’ Centre, Dee Why but there is a veteran services’ vacuum in the rest of SMR. To be effective, care for a veteran, their family and support network needs to begin prior to and at the time veteran transition occurs and be ongoing. The Ryde LGA Veteran Centre should be funded to allow support of the younger veteran community, to provide advocacy and assistance in applying to the DVA for benefits and counselling, financial planning and outreach programs for the veterans, their families and support network.
**Suggested funding options:**
- DVA financial grant for the provision of Pension and Welfare services
- Ryde LGA grant
- Sponsorship from North Ryde RSL

**Suggested location:** North Ryde RSL (Veteran Centre offices within complex)

**Recommendation 2: Younger veteran programs in Ryde LGA**

Two of the three RSL organisations within Ryde LGA have one younger veteran (both of whom are volunteer executives) each. As a result there are no programs within those institutions for younger veterans and their families. This is a significant gap in the Ryde LGA. It is impossible to understand what a younger veteran requires and needs unless their voice is included in the decision-making process. As a corollary to this research, it is suggested the Ryde LGA should respond by instituting younger veteran health, lifeskills and health behaviour programs that reach out to the younger veterans and their families/support network. Veterans emerge from their ADF career with a number of skills including leadership, discipline, time management, teamwork and adaptability. It is suggested that opportunities be given for younger veterans to take on volunteer roles within the veteran programs. Veteran volunteers could also be appointed as mentors to younger veterans, particularly those with health, health behaviour and wellbeing issues and problems with rebonding with their community on transition.

**Suggested funding options:**
- Ryde LGA grant
- Sponsorship from North Ryde RSL or affiliation with Soldier On, Concord West Centre
- Northern Area Health (Health Promotion) grant

**Suggested program assistance:** Macquarie University PACE

**Suggested location:** North Ryde RSL or Ryde LGA premises

**Recommendation 3: Establish a sponsored younger veteran webpage link on the Ryde LGA website**

A webpage link on the Ryde LGA website can provide sponsored links to its home page, upcoming younger veteran events, Ryde LGA newsletters, contact details for access to the Veterans’ Centre (Ryde) (if established) and webpage links to the DVA, Defencecare, veteran organisations and other government departments, services and agencies. This website link is potentially a gateway for younger veterans to capture economic, social and cultural benefits and health resilience outcomes.

**Suggested funding option:** Ryde LGA grant

**Recommendation 4: Establish a younger veteran information and forum link on the Ryde Veterans’ Centre website (if veteran centre is established)**

Setting up a password protected email facility for younger veterans on the Veterans’ centre website will require targeted marketing. Veterans could be encouraged to make use of the email facility to contact Veterans’ Centre executive and administrative services. The email facility
would allow prompt messaging and response time. The provision of a password protected 'communal e-space' via an informal Discussion Board, moderated and managed by the Veterans’ Centre would provide veterans with a social networking facility, opportunities to share dialogue and gain knowledge and coping skills with the Veterans’ centre and from each other. Linking younger veterans to social networks and support may be just the necessary catalyst required to encourage positive individual health behaviour. Such an intervention would allow veterans to be better equipped to cope with rebuilding their life and meeting the demands of transition in their own local community. A ‘Frequently Asked Questions’ (FAQs) site should be designed to deliver relevant responses for a variety of circumstances, address common concerns and provide guidance as to veteran services and benefits at any time.

Mindful of the high level of reported depression and PTSD in the younger veteran population, it is suggested the ‘webpage links’ site could also direct users to health and welfare services such as Defencecare, Lifeline and specific parental and carer organisations.

Suggested funding options:

- Ryde LGA grant
- DVA grant
- Northern Area Health (Health Promotion) grant

Acknowledgements

I wish to acknowledge and thank the Macquarie-Ryde Futures Partnership for giving me the opportunity to conduct this research; the veterans who generously gave their trust and time to the research project; the executive and staff of the veteran organisations named in this report; my mentor Professor Nonna Martinove-Bennie for her valuable advice and Professor Richie Howitt for his faith in the project.
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