Chapter 3
Suicide by veterans

Introduction

3.1 The first term of reference of the committee's inquiry is 'the reasons why Australian veterans are committing suicide at such high rates'. This chapter will consider issues relating to this term of reference. This includes the incidence of suicide by ADF members and veterans, including recent results by the Australian Institute of Health and Welfare (AIHW). On-going and future research into the welfare of veterans including mental health issues and suicidality will be examined. It will consider the range of identified contributing factors to suicide by veterans and the approach of DVA to suicide prevention. Finally, this chapter will examine issues relevant to veterans accessing appropriate mental health assistance.

The incidence of suicide

Suicide in Australia

3.2 Suicide is a leading cause of death in Australia. A suicide occurs when a person dies as a result of a deliberate act intended to cause the end of his or her life. In 2015, 3,027 people died from intentional self-harm. This is up from 2,864 in 2014. The age-standardised death by suicide rate was 12.6 per 100,000 persons and it is the 13th leading cause of death. In 2015, suicide was the leading cause of death among all people 15-44 years of age and the second leading cause of death among those 45-54 years of age.[1]

3.3 Around three quarters of deaths by suicide are male. Attempted suicide is also an important health issue with estimates that as many as 30 people attempt to end their lives for every death by suicide, the majority being women. For Aboriginal and Torres Strait Islander peoples the suicide rate is more than double the national rate.[2]

Suicidality in ADF population

3.4 The 2010 ADF Mental Health Prevalence and Wellbeing Study (MHPW study) found that the rate of suicidality (thinking of suicide and making a suicide plan) in the ADF was more than double that in the general community; however the number of suicide attempts was not significantly greater than in the general community and the number of reported deaths by suicide in the ADF were lower than in the general population when matched for age and sex.

3.5 The MHPW study found that, although ADF members are more symptomatic and more likely to express suicidal ideation than people in the general community, they are only equally likely to attempt suicide and less likely to complete the act. This

1 Australian Bureau of Statistics, *Australia's Leading Causes of Death*, September 2016.

2 Australian Bureau of Statistics, *Australia's Leading Causes of Death*, September 2016.

suggested that 'the comprehensive initiatives on literacy and suicide prevention currently being implemented in Defence may, in fact, be having a positive impact'.[3]

3.6 Defence advised the committee that between 1 January 2000 and 29 September 2016, 118 full-time serving ADF members were suspected or confirmed to have died by suicide. Of these 37 were with the Royal Australian Navy, 60 with Australian Army and 21 with the Royal Australian Air Force (as at 20 September 2016). Eight were female.[4]

3.7 Defence commented that for serving ADF members, based on the available data, there does not appear to be any discernible trend in the number of deaths by suicide nor is there any clear association with operational deployment. Of the 118 ADF members confirmed or suspected to have died by suicide 64 had never deployed. Of the 54 who had deployed, 22 had one or more deployments to the Middle East Area of Operations.[5]

Suicidality in ex-service population

3.8 DVA reported that '[a]s at 31 March 2016, DVA has determined claims in relation to 83 deaths by suicide in the ten years to 31 December 2015'. Of these 56 were accepted by DVA as service related.[6] DVA also outlined the practical difficulties in assessing deaths by suicide in the veteran community. While DVA indicated that it was working with other agencies to improve understanding of the prevalence of suicide among ex-serving personnel, it has previously acknowledged that it 'is unlikely to ever obtain complete information in relation to the prevalence of suicide amongst all those who have served with the [ADF]'.[7]

3.9 DVA generally only becomes aware of a former member's death by suicide if a dependant submits a claim for compensation or income support. During the inquiry, the Returned & Services League (RSL) noted that this meant that if 'veterans do not have dependents and a claim is not lodged then the cause of death will not be recorded by DVA'. Furthermore:

> Death can be 'automatically' accepted in a range of situations…In situations where there is an 'automatic' acceptance of death and the subsequent granting of benefits to the dependents, or where the veteran had no dependants, there will be no recording of the cause of death centrally through DVA, regardless of whether a coroner may have determined that the cause of death was suicide.[8]

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3 Defence, *Mental Health in the Australian Defence Force: 2010 ADF Mental Health Prevalence and Wellbeing Study Report*, p. xiv.

4 Defence, *Submission 124*, p. 5.

5 Defence, *Submission 124*, p. 6.

6 DVA, *Submission 156*, p. 3.

7 DVA, responses to questions on notice from public hearing on 13 August 2014, p. 2.

8 *Submission 216*, p. 8.

Australian Institute of Health and Welfare

3.10 In 2016, the AIHW was commissioned by DVA to calculate accurate numbers and rates of suicide deaths among serving personnel, reservists and ex-serving ADF personnel. Key information was derived from the Defence PMKeyS database, the National Death Index (NDI), the Defence Suicide Database and the National Mortality Database. The AIHW report noted:

> Cause of death (suicide) data were obtained only from certified sources; that is, official fact of death and cause of death determination (including suicide death) from the Registrars of Births, Deaths and Marriages in each state and territory and the National Coronial Information System…Reporting only certified deaths ensures that the results presented here are defensible, comparable over time and can be reproduced. Differences between the results of this study and other publicly reported estimates may be due to differences in scope and/or the source of cause of death information.[9]

3.11 Before the AIHW results were released, DVA cautioned that there would be data limitations. It noted that the specific time-range of the cohort considered 'means it's not possible to extrapolate the findings to the broader ex-serving community' and it would not be possible to 'simply compare counts of death due to suicide between the different services types and the Australian population'.[10]

3.12 On 30 November 2016, the AIHW released its initial study. The AIHW found that between 2001 and 2014, there were 292 certified suicide deaths among people with at least one day of ADF service since 2001. Of these:

- 84 occurred in the serving full-time population;
- 66 occurred in the reserve population;
- 142 occurred in the ex-serving population; and
- 272 were men and 20 were women.[11]

3.13 In particular, the AIHW study found that after adjusting for age, when compared with all Australian men, that men serving full-time and in the reserve had a lower suicide rate (53 per cent and 46 per cent). However, the suicide rate for ex-serving men was 13 per cent higher. It noted:

> In 2002-2014, younger ex-serving men were at higher risk of suicide death compared with all Australian men of the same age. Among ex-serving men, those aged 18-24 accounted for 1 in 6 suicide deaths (23 deaths, 17%) and

9 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. 5.

10 *Submission 156*, p. 4.

11 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014*, November 2016, p. 1.

> had a suicide rate almost 2 times as high as Australian men of the same age. This difference was statistically significant.[12]

3.14 In its summary report, released in June 2017, the AIHW found that between 2001 and 2015, there were 325 certified suicide deaths among people with at least one day of ADF service since 2001. Of these deaths:

- 51 per cent (166) were of people no longer serving at the time of their death;
- 21 per cent (69) were of people serving in the active and inactive reserves at the time of their death;
- 28 per cent (90) were of people serving full time at the time of their death; and
- 93 per cent (303) were men and 7 per cent (22) were women.

3.15 The AIHW stated:

> The suicide rates of ex-serving men were more than twice as high as for those serving full time or in the reserve (26 suicide deaths per 100,000 people, compared with 11 and 12 per 100,000, respectively). They were also slightly higher than for their counterparts in the general population after adjusting for age (14% higher, however this difference was not statistically significant).
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> Ex-serving men aged 18-24 were at particular risk—2 times more likely to die from suicide than Australian men of the same age.
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> Ex-serving men aged 25-29 accounted for slightly more deaths than other age groups and were 1.4 times more likely to die from suicide than Australian men of the same age. This difference was not statistically significant.
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> Men serving full time or in the reserve had significantly lower suicide rates than for men in the general population (53% and 49% lower, respectively), after adjusting for age.[13]

3.16 The AIHW summary report identified several risk groups among ex-serving men. These included:

- suicide rates for ex-serving men aged 18–49 were between 3 and 4 times as high as for men aged 50–84;
- those who were discharged involuntarily (suicide rates were 2.4 times as high as for those discharged for voluntary reasons), particularly if the discharge was for medical reasons (3.6 times as high as for those discharged for voluntary reasons);
- those who left the ADF after less than 1 year of service (2.4 times as high as for those who had served for 10 years or more); and

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12 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014*, November 2016, p. 2.

13 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. vi.

- all ranks other than commissioned officers (2.8 times as high as for commissioned officers).[14]

3.17 The AIHW observed that that despite methodological differences, the findings of the study in relation to the influence of age, rank, length of service and time since discharge on rates of suicide were 'consistent with findings from studies of ex-serving defence personnel across the United Kingdom, Canada and the United States'. While it was not possible to analyse the effect of operational service, the AIHW noted that 'as the study progresses and data for more years is added, it may be possible to explore suicide rates' for veterans with these service characteristics in more detail.[15]

Research and data collection

3.18 The AIHW study is a component of a range of research funded by both Defence and DVA into the health and well-being of serving members and veterans, particularly in relation to mental health. For example, Defence and DVA have created a database, the Military and Veteran Research Study Roll (held by AIHW) of contact details of members who transitioned out of the ADF between 2010 and 2014 to facilitate future research.[16]

3.19 A current large scale research project is the Transition and Wellbeing Research Programme (TWRP). This will examine the impact of contemporary military service on the mental, physical and social health of serving and ex-serving personnel and their families, and builds on previous Defence research such as the Military Health Outcomes Program (MilHOP). The TWRP will consist of three major studies:

- Mental Health and Wellbeing Transition Study;
- Impact of Combat Study; and
- Family Wellbeing Study.[17]

3.20 DVA outlined that its strategy for research into mental health was guided by the DVA Corporate Plan 2016-2020 and by the *Veteran Mental Health Strategy (A Ten Year Framework) 2013-2023*:

> The Corporate Plan sets out DVA's commitment to better understanding the health needs of veterans through a continued focus on research over the next four years and beyond, especially in relation to rehabilitation and

14 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. vii.

15 AIHW, *Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2015: in brief summary report*, June 2017, p. 29.

16 DVA, 'Military and Veteran Research Study Roll', available at: https://www.dva.gov.au/health-and-wellbeing/research-and-development/military-and-veteran-research-study-roll (accessed 28 July 2017).

17 CTSS, 'Transition & Wellbeing Research Programme', available at: http://health.adelaide.edu.au/ctss/research/military/transition-wellbeing-research-programme/ (accessed 16 May 2017).

> mental health, with a strong emphasis on early intervention to improve clients' prospects of recovery.
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> This priority is also reflected in the *Veteran Mental Health Strategy (A Ten Year Framework) 2013-2023*. Under this Strategy, Strategic Objective 6 is "Build the Evidence Base". As a significant purchaser of mental health services, DVA needs a strong evidence base for best practice veteran mental health services, treatments and interventions.[18]

3.21 However, despite these research programs many submitters and witnesses highlighted the problems with current research into veteran suicide and that lack of accurate data collection which could be used to improve the welfare of veterans. For example, the RSL pointed out it was 'currently impossible to tell how many veterans live in Australia today':

> While our best guess that the numbers are between 310,000 (the number of Australian Defence Medals issued by 2010) and 500,000, there is no dataset that can provide a definite number. Similarly, there is currently no dataset that will provide information on the number of veterans receiving healthcare.[19]

3.22 The RSL argued that a 'way of identifying and recording causes of death for all serving members and veterans needs to be established'. It made a number of recommendations for gathering information on veterans through the census, coronial reports, police reports and audits specific cases.[20]

3.23 Suicide is recognised to be an inherently difficult social phenomenon to study due to community stigma, underreporting, and in some circumstances, uncertainty relating to cause of death. In particular, information concerning military and ex-military personnel may have a 'healthy worker' bias, due to recruitment standards and training in the ADF, which meant that the suicide rate amongst serving and ex-serving members cannot be directly compared to the general population. For example, the Vietnam Veterans' Federation of Australia (VVFA) noted:

> ADF members are screened psychologically and medically as part of a rigorous selection procedure. They are then systematically trained to cope with the high levels of physical and emotional demand necessary for sustained performance in operational roles. It is therefore reasonable to hypothesise that the incidence of suicide within currently serving and ex-serving veterans should be less than for the general population, and this hypothesis is supported by research. If it is the same, or higher, then 'something' has intervened, and there is again, research evidence to support that it is higher than would be expected. [21]

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18 DVA, response to written question on notice from 6 February 2017 public hearing.

19 *Submission 216*, p. 5.

20 *Submission 216*, p. 7.

21 *Submission 277*, pp 6-7.

3.24 In July 2016, the Australian Institute for Suicide Research and Prevention (AISRP) published a literature review regarding suicide amongst veterans in Australia and internationally, and how this compares to the general population. One of its findings was that there is 'very limited research information focusing specifically on suicide mortality, non fatal suicidal behaviour or suicidal ideation among individuals who have left the Australian Defence Force'.[22] It described the lack of information about suicide mortality among ex-serving Australian personnel as a 'serious shortcoming in current knowledge'.[23]

3.25 Similar concerns were expressed by submitters. For example, Suicide Prevention Australia also considered '[t]he lack of research comprehensively and specifically addressing suicidal behaviour among Australian veterans is itself an issue: investment in research is urgently required to uncover the reasons Australian veterans and ex-service personnel are dying by suicide and how suicidal behaviour among this population can be prevented'.[24] The South Australian Government also observed that '[w]ithout accurate data it is difficult to fully understand the magnitude of the issue although it is considered that a zero tolerance of suicide amongst the veteran community is a suitable aspirational target and statistical evidence of one suicide is sufficient to warrant serious consideration'.[25]

3.26 There is no national suicide register in Australia, although some states have established registers for their jurisdictions. Dr Kairi Kolves from the AISRP, which administers the Queensland Suicide Register, underscored the difficulties in identifying veterans who have taken their own lives:

> Identifying ex-serving members is pretty challenging, because when police arrive at the scene, there is often no information as to whether the person has been an ex-serving member, unless it is indicated by family members who knew about it. If the informant happens to be somebody else, it is likely that they will miss it. A similar thing happens with the National Coronial Information System.[26]

3.27 The lack of an official register of serving and ex-serving members who commit suicide was highlighted during the inquiry. Growing awareness regarding suicide by ex-service men and women has led to members of the community such as the *Australian Veterans Suicide Register* to unofficially highlight incidence of suicide.[27] Some raised concerns with the committee that the lack robust official

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22 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, p. 18.

23 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, p. 28.

24 *Submission 176*, p. 2.

25 *Submission 187*, p. 3.

26 *Committee Hansard*, 2 February 2017, p. 2.

27 Available at: https://www.facebook.com/AustralianVeteransSuicideRegister/ (accessed 12 July 2017).

statistics would allow 'others to sensationalise suicide on social media' and may contribute to increase suicidal ideation.[28]

3.28 Some submitters supported the introduction of a publicly maintained register of suicide amongst ex-military personnel.[29] Slater and Gordon Lawyers argued that the data from the AIHW study 'needs to be gathered on a regular basis and made publicly available in a de-identifiable format'. It considered that this was 'only way that the extent of the issue can be properly quantified and understood, and then steps toward a meaningful solution strategy taken'.[30] Mr Arthur Ventham proposed that a '[m]ilitary suicide register should be funded to collect the true number of service and ex-service suicides' with cross-matched data from state coroners' offices, the ADF and police.[31] The Catholic Women's League of Australia also urged the Australian Government to establish a 'government funded and managed data base/register on suicide':

> Data collection is paramount to gaining a better understanding of how widespread suicide is in the armed forces, and being able to take steps to support those who need support and prevent it from happening. Without an accurate snap shot of the magnitude of the problem efforts to rectify the situation can only be half-hearted at best. Furthermore, a lack of data results in a lack of research and national plan formulation on the issue, only serving to exacerbate the stigma and shame that is so prevalent around this issue. However, this is an initiative that needs to be supported, funded and managed by the Australian government, to ensure consistency and accuracy of data.[32]

3.29 Relevant areas for further research were also highlighted. For example, Dr Andrew Khoo, a consultant psychiatrist, recommended work into 'concepts which are recently coming under the heading of "Moral injury" and their possible contribution to suicidal behaviour'. Moral injuries could include 'guilt over what was or wasn't done and coming to terms with perceived betrayals and losses'. He noted that 'young men and women have difficulty resolving the deprivation, disease and death they have encountered, and the horror of what one human can do to another'.[33]

3.30 The NMHC report considered that '[c]ontinued research is required to develop a comprehensive understanding of suicide and self-harm within current and former members of the ADF, and their families. It supported the development of a long-term research program focussed on mental health and wellbeing, and the prevention of suicide and self-harm in conjunction with expert bodies and taking in account current research such as the TWRP and the AIHW. In particular, the NMHC recommended:

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28 For example, Ms Julia Langrehr, *Committee Hansard*, 17 November 2016, p. 46.

29 For example, Slater and Gordon Lawyers, *Submission 160*, p. 7.

30 *Submission 160*, p. 7.

31 *Submission 295*, p. 12.

32 *Submission 405*, p. 4.

33 *Submission 155*, p. 7; also Mr Gordon Smith, *Submission 230*, p. 5.

> The Department of Defence should periodically commission (e.g. every 2-5 years) repetition of the data-linking study undertaken by the AIHW that examined the risk of suicide in current and former serving members. It is only in this way that a more accurate picture of the true risk of suicide can be built up over the next generation of military service.[34]

3.31 In its response to the NMHC report, the Australian Government stated that it intended 'that AIHW provide regular updates on the suicide data linkage study to improve the understanding of the true risk of suicide'. It noted that DVA and Defence were 'currently in discussion with AIHW for the continuation and regular updating of this study'.[35]

Identified contributing factors

3.32 A broad range of interrelated factors were identified as contributing to the incidence of suicide by veterans. These included both factors which affect the general population and factors which were linked to the experiences of those persons who have served in the ADF. In the general community, DVA noted that 'factors can include pain, despair, guilt, shame, recklessness or an expression of a person's right to choose the manner of their death'.[36] Phoenix Australia listed a number of identified risk factors associated with suicide including:

- historical factors, such as any history of suicide attempts, past abuse, family history of suicide, and family history of mental health problems;
- mental health factors, such as current mental health problems and recent discharge from an inpatient mental health unit;
- demographic factors, such as male gender and divorced or widowed marital status, with peaks between the ages of 40-54 and over 80;
- social factors, such as social isolation, loss of relationship, financial difficulty, and critically, having access to means for suicide; and
- medical factors, such as chronic pain and physical health problems.[37]

3.33 The recent AISRP report on 'Suicidal behaviour and ideation among military personnel: Australian and international trends' noted that a 'qualitative analysis of the case studies concluded that the reasons for suicide among veterans are multidimensional and include a range of veteran-specific risk factors such as difficulty returning to civilian life (relationship problems, mental illness, alcohol and drug misuse, employment problems, bereavement, and loss of the routine and structure that

34 NMHC report, p. 55.

35 Government response to the NMHC report, p. 72.

36 *Submission 156*, p. 1.

37 *Submission 177*, p. 2.

characterise a military lifestyle) and veterans' reluctance to seek help for their problems'.[38]

3.34 Submitters to the inquiry highlighted a range of issues which contribute to veteran suicide, self-harm and ideation. These included:

- mental health issues, including depression and post-traumatic stress disorder (PTSD);
- homelessness, poverty and lack of income;
- unemployment and low job security;
- stress on personal relationships and family violence;
- social isolation and lack of connectedness;
- experiences of sexual assault, bullying and harassment in the ADF;
- perceived maladministration within the military justice system;
- the side effects of mefloquine (anti-malarial drugs); and
- substance and alcohol abuse.

3.35 Suicide Prevention Australia recommended consideration of Thomas Joiner's interpersonal-psychological theory of suicidal behaviour which posits three key factors in determining the risk of an individual engaging in a lethal suicide attempt. These factors were 'perceived burdensomeness', 'thwarted belongingness', and 'acquired capability for suicide'. It detailed how these factors were relevant to the experiences of veterans.[39] Similarly, Dr Frank Donovan, a former mental health social worker, noted:

> Suicide has commonly been associated with experiences like alienation from family, community, previous friendship networks, employment and even intimate partners – leaving the potential suicide with no support, sense of self-worth, future or a 'life worth living'. Bereft of their former military milieu which provided for all of these important features of life, suicide is perhaps seen as the 'best way out' of the veterans new sense of meaninglessness.[40]

3.36 Dr Andrew Khoo outlined the risk factors for suicide identified by the US based Center for Disease Control and Prevention which included a 'history of mental disorders' and 'physical illness'. He noted:

> Exposure to trauma (either during deployment, training exercises or workplace accidents/incidents) during military service is associated with increased risk of psychological injury. Depending on which research you peruse 12 month prevalence rates for mental disorders vary between 20-

38 AISRP, 'Suicidal behaviour and ideation among military personnel: Australian and international trends', *Technical report*, July 2016, pp 18-19.

39 *Submission 176*, pp 3-5.

40 *Submission 257*, p. 2.

> 30% for returned service people, with lifetime prevalence rates of greater than 50%. These rates are significantly higher than matched civilian cohorts. Suicide research informs us that up to 90% of completed suicides have diagnosable mental illness.
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> Comorbidity rates of Alcohol and Drug Use Disorders in populations with combat related PTSD are as high as 60-80%. Recent US VA statistics show that 1 in 10 returning personnel have an active drug or alcohol problem. Whilst the general trend is for serving personnel to have decreased rates of Substance Use Disorders (SUDs) compared with the civilian population (ADF prevalence study, US DoD statistics), rates of SUDs accompanying PTSD and other mental health disorders following service are significant. Of concern is the effect of both Australian and military culture which has historically advocated alcohol use as a coping mechanism for stress. Particularly as alcohol and/or drug intoxication reduces judgment making suicide attempt and success more likely…
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> There are a number of chronic physical conditions which typify the medical presentation of serving and ex serving military personnel. These include hearing loss, tinnitus, degenerative osteoarthritic conditions of weight bearing joints (ie the neck, shoulders, lower back, hips, knees and ankles), gastro-oesophageal reflux disease, irritable bowel syndrome and sexual dysfunction. These chronic conditions covey significant pain, disability and impairment and hence may contribute to numerous functional losses and a sense of loss of worth, hope or esteem.[41]

3.37 The unique nature of military training and the impacts of the stress caused by training to veterans was also highlighted. For example, the Defence Force Welfare Association (Queenland) observed that '[f]rom the outset, ADF members are deliberately exposed to violence and are trained to react and continue working in stressful and often dangerous situations'. It noted that there have been many major and minor accidents where ADF members have been injured and/or killed on duty whilst training for war. It stated that 'training environment stressors can have a deleterious effect on the mental health of individuals whether or not they make it through the training program' and suggested that 'this may be a contributing factor in some suicidal events'.[42]

3.38 Recent deployment structures were identified as putting additional stress on some military personnel, with multiple deployments perceived as increasing the risks of the development mental health problems.[43] Limited recovery-time between deployments also was seen as putting additional stress on veterans and their families.[44] For example, Mr Max Ball drew the committee's attention to a U.K. Ministry of

41 *Submission 155*, p. 4.

42 *Submission 148*, p. 2.

43 For example, Mr Allan Thomas, *Submission 399*, p. 3.

44 Ms Narelle Bromhead, *Committee Hansard*, 18 November 2016, p. 15.

Defence recommendation that military personnel be deployed for six months at a time and for less than twelve months in any three-year period.[45]

3.39 While a wide range of factors were identified there were two particular factors which were a focus in the evidence for the inquiry: PTSD and the compensation claims process.

Post-traumatic stress disorder

3.40 Post-traumatic stress disorder (PTSD) is a set of reactions that can develop in persons who have been through a traumatic event which threatened their life or safety, or those around them. Royal Australian and New Zealand College of Psychiatrists (RANZCP) highlighted the 'well-researched correlation between suicidality and PTSD:

> Exposure to traumatic events significantly increases the risk of suicidal ideation and behaviour. The relationship between trauma and suicidality has been found to exist independent of psychiatric disorders although comorbidities with mood and substance abuse disorders may still be factors. Numerous studies have demonstrated a positive relationship between cumulative trauma and suicidality.[46]

3.41 In particular, it emphasised the need for customised treatments for military-related PTSD. The best-practice treatment for patients with PTSD in the general population, may not constitute an apt approach to the treatment of military-related PTSD. It noted:

> There are a number of particular treatments which may present significant benefits for veterans and ex-service personnel but which may be inaccessible or even disallowed. Private hospital day programs and community services are good examples of treatment settings to which veterans require increased access. Family-centred approaches to treatment may also be useful considering the potential effects of mental ill health on the 'families of veterans and ex-service personnel suffering from PTSD.[47]

3.42 The treatability of PTSD was also emphasised by health professionals and experts. For example, Dr Robert Tym highlighted evidence of the effectiveness of Eye Movement Desensitisation and Reprocessing in treating and managing types of PTSD. Dr Kerr from AISRP noted that, with treatment, military personnel can return to being 'deployable again':

> There is this culture that people still think that PTSD or other mental health disorders cannot be gotten rid of. And they can be. We have excellent treatments for some of these disorders, and they go into remission meaning that they no longer have these disorders. And, for those people, there is no reason why they should not still be in the uniform.[48]

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45 *Submission 323*, p. 2.

46 *Submission 165*, p. 9.

47 *Submission 165*, p. 12.

48 *Committee Hansard*, 2 February 2017, p. 7.

The compensation claims process

3.43 Many submitters identified delays, negative determinations or perceived maladministration in DVA the compensation claim processes as creating critical stress for veterans and as a contributing factor to suicide. For example, Suicide Prevention Australia commented that it had 'received feedback from multiple sources that the processes involved in engaging with DVA are perceived to exacerbate veterans' stress and we posit that this may add to the perception of perceived burdensomeness and thwarted belongingness, and therefore suicide risk'.[49] Similarly, the AISRP submission listed a number of risk factors for suicide by veterans, including:

> Unfortunately the DVA compensation system is complex and slow, and provides disincentives to work depending on the compensation Act the person falls under. Additionally, veterans report that they feel a sense of uncertainty regarding their future and feel they cannot progress their lives until their compensation issues are finalised. They explain feeling paralysed, 'in limbo'.[50]

3.44 These concerns regarding the impact of the claims process were also evident in submissions from veterans, their families, advocates and others. For example, John and Karen Bird told the committee about their son Jesse who had been diagnosed with PTSD and other mental health conditions:

> He has been endeavouring to seek assistance from DVA for the last eighteen months without success - it seems to him and us that the level of bureaucracy is intentionally obstructionist and unedifying. The jungle of paperwork, the lack of follow-up and the non-existent support has contributed to his deteriorating mental health. He is involved with VVCS and is currently involved in a 12 Week PTSD Specific Counselling program which finishes in early December. Jesse has not received any money what-so-ever from DVA or Centrelink to help him survive and without our financial and emotional help he would be on the street or worse.[51]

3.45 Subsequently, Jesse took his own life. His former partner, Ms Connie Boglis, outlined the problems Jesse had after his service:

> Jesse did not have a 'Part time' 6-10 scale PTSD, Jesse had PTSD Everyday! Jesse was trained to run into the face of fear, you taught him that. You broke him down before he even left for war and if that wasn't enough, he was deployed to Afghanistan for 9 months when it was only meant to be 6. The day Jesse landed on Australian soil he should have been handed a white card, given a pension and options for supports thereafter if he choose. Instead Jesse was expected to pour out his wounds from the battlefield to a complete stranger and talk emotions, something you taught him to hide so well. Well he did it, Then you made him wait, in hope that his voice would be heard, So we continued to wait, I couldn't wait any

49 *Submission 176*, p. 7.

50 *Submission 174*, p. 3.

51 *Submission 317*, p. 1.

> longer, So Jesse tried to wait a little more and fight on his own but you never came.[52]

3.46 Mr Peter Thornton, another veteran, described the DVA disability claims process as 'challenging' and weighing 'heavily upon one's mental health and well-being, generally at a time when one is at an extremely low ebb'. While he accepted the need for a 'rigorous process that thwarts fraud', he perceived the process itself 'could be a contributing factor to suicidal ideation and/or actual suicide itself, by Veterans who are under immense pressure'.[53] Another veteran, Mr Shaun Young, highlighted the difficulties for those with mental health issues in interacting with DVA:

> When you suffer day to day with major depression, life is already hard to get through. You literally have to take it one day at a time. Then you have to call DVA on one of those days and suddenly you're thinking to yourself 'what's the point of this bulls**t?' You're in a constant battle with yourself and then DVA make it so you have to battle them.[54]

3.47 In this context, Dr Nick Ford, a psychiatrist who works with veterans, drew the committee's attention to a 2014 study which examined the aspects of claims processes that claimants to transport accident and workers' compensation schemes find stressful and whether such stressful experiences were associated with poorer long-term recovery.[55] This study concluded that:

> Many claimants experience high levels of stress from engaging with injury compensation schemes, and this experience is positively correlated with poor long-term recovery. Intervening early to boost resilience among those at risk of stressful claims experiences and redesigning compensation processes to reduce their stressfulness may improve recovery and save money.[56]

3.48 RANZCP noted that there was 'an increasing body of evidence indicating that delays in claim settlement, inappropriate decisions and unnecessary obfuscation in administrative processes can serve to significantly worsen the distress and severity of a veteran's condition'. It believed that 'the compensation system would benefit from a reconceptualisation of compensation as part and parcel of the health-care system to ensure that the processing of justified compensation claims do not adversely affect health outcomes'.[57]

3.49 Others cautioned against focusing on one factor when the issues relating to veteran suicide were clearly complex. For example, the Alliance of Defence Service

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52 *Submission 433*, p. 4.

53 *Submission 335*, pp. 14-15.

54 *Submission 252*, p. 2.

55 *Committee Hansard*, 17 November 2016, p. 6.

56 Genevieve Grant et al, 'Relationship Between Stressfulness of Claiming for Injury Compensation and Long-term Recovery: A Prospective Cohort Study', *JAMA Psychiatry*, 71(4) 2014, pp 446-456.

57 *Submission 165*, p. 2.

Organisations (ADSO) considered that 'DVA's responsibility for contributing to veteran suicidality must, however, be tempered by a reality that seems to suggest that only 20% of people transitioning out of the ADF become automatic DVA clients, and around another 15% eventually become DVA clients after transition has occurred'. Nonetheless, ADSO recommended:

> The perception that the rehabilitation and compensation decision process is unreasonable, oppressive, and runs counter to timely and equitable support, and therefore contributes to veteran suicide, should be investigated. Whether the bureaucratic focus on due process is an exacerbating factor and is contributing to veteran suicide should be investigated.[58]

Suicide prevention

3.50 The government response to the committee's report into the mental health of the ADF members and veterans in September 2016 described suicide prevention 'for serving and former serving ADF members at risk and support to the families who have been affected by the tragedy of suicide' as a 'high priority':

> The Government's current suicide prevention strategy includes training to assist at-risk individuals, programs to build resilience, self-help and educational materials, a 24-hour support line, and access to clinical services. The Government is continuing to invest in initiatives to prevent suicide among current and former serving personnel and support those affected by it. As part of the 2016-17 Budget, funding of $1 million has been provided to continue the suicide awareness and prevention workshops and to pilot an alternative approach to suicide prevention in the veteran community. This is in addition to the $187 million a year that the Government already spends in relation to veteran mental health. [59]

3.51 DVA outlined that the *'Veteran Mental Health Strategy 2013-2023* provides a ten year strategic framework to support the mental health and wellbeing of the ex-service community'. Funding for mental health treatment is demand driven, and is not capped and DVA spends around '$187 million a year on supporting the mental health needs of its clients'.[60]

3.52 The NMHC report contained a useful summary of services available to veterans through DVA. These included:

- post-discharge GP health assessments;
- mental health treatments through:
  - GP, psychologist, psychiatrist, and social work services
  - pharmaceuticals

58 *Submission 172*, p. 8.

59 Government response to Senate Foreign Affairs, Defence and Trade Committee report, *Mental Health of Australian Defence Force Members and Veterans*, September 2016, p. 3.

60 *Submission 156*, p. 5.

- in-patient and out-patient hospital treatment

- services through Veterans and Veterans Families Counselling Service (VVCS), including a 24-hour crisis line, counselling, group treatment programs';
- DVA's Operation Life suicide prevention program, which includes face-to-face workshops, a website and an app;
- online resources, including DVA's At Ease online mental health portal, PTSD Coach Australia app, High Res website and app (stress and resilience program), and The Right Mix website and On Track with the Right Mix app (alcohol management program); and
- a range of health and wellbeing programs such as Stepping Out (transition program), Day Club, Men's Health Peer education, and Veterans Health Week.[61]

3.53 The NMHC report noted that mental health treatments for former serving members can be delivered by practitioners who are registered to provide services under the Medicare Benefits Schedule (MBS). These services are paid for by DVA through arrangements that guarantee no out-of-pocket costs for eligible services that are accessed by holders of Gold and White cards. Other mental health treatment services are paid for by DVA via contracted arrangements with providers, such as private hospitals.

3.54 It also noted that former members of the ADF 'have access to services in the general community, including state/territory public health systems, broader public health initiatives and services provided by non-government organisations including ex-service organisations (ESOs), and post-traumatic stress disorder (PTSD) treatments services in the community'.[62] In November 2015, as part of its response to the NMHC report of mental health programs, the Australian Government announced a renewed approach to suicide prevention through the establishment of a new National Suicide Prevention Strategy. In particular, the strategy was being led by Primary Health Networks (PHNs) in partnership with local hospital networks, states and territories, and other local organisations with funding available through a flexible funding pool. On 28 May 2017, the Hon Greg Hunt MP, Minister for Health, announced a '$47 million boost to front-line services for suicide prevention and directly address a growing community need'.[63]

61 NMHC report, p. 26.

62 NMHC report, p. 26.

63 The Hon Greg Hunt MP, Minister for Health, 'Providing $47 million for suicide prevention work across Australia', *Media release*, 28 May 2017.

Table – DVA overview of mental health expenditure in 2014-15[64]

Category	$m	Description
Private Hospitals	43.3	Contracts with private hospitals for the purchase of emergency, acute care and outpatient mental health services for the veteran community.
Public Hospitals	39.4	Arrangements with all state and territory governments. Public and private hospitals expenditure also includes 13 trauma recovery programs for posttraumatic stress disorder provided in hospitals around the country.
Psychiatrists	21.7	Provide psychiatric assessments, diagnoses, medicine management and clinical reviews as well as ongoing treatment.
Veterans and Veterans Families Counselling Service (VVCS)[1]	32.6	Counselling support and mental health treatment by psychologists and mental health accredited social workers. Includes case management services, group programs.
Pharmaceutical	17.2	Includes anti-depressants, psycho stimulants and dementia-related drugs.
Allied Mental Health Workers	5.4	Provide assessments and consultations, including group and individual therapies from professionals such as psychologists or social workers.
General Practitioners	23.1	Provide mental health assessment and access to treatment.
Australian Centre for Posttraumatic Mental Health (now Phoenix Australia)	1.4	Provides evidence based expert advice to inform and underpin DVA's policies and programs.
Mental health budget measures	3.1	Population measures including *At Ease* website; mobile phone applications; and provider engagement training and resources.
TOTAL	187.2	

Veterans and Veterans Families Counselling Service

3.55 In particular, DVA highlighted the work of the Veterans and Veterans Families Counselling Service (VVCS) as a frontline mental health service for the veteran community. VVCS provides a range of services including clinical support and

64 *Submission 156*, p. 6.

counselling options to veterans and their families who are experiencing service-related mental health and wellbeing conditions. DVA noted:

> In 2014-15, through its nation-wide network that includes 14 centres, a range of satellite centres, and more than one thousand contracted outreach clinicians, VVCS delivered 92,861 counselling sessions to 14,627 clients. An additional 5,350 clients had their concerns resolved at intake, 1,610 clients participated in group programs and 6,571 people received after hours support.[65]

3.56 In its mental health report in 2016, the committee recommended that eligibility requirements for VVCS be consolidated and broadened to include all current and former members of the ADF and their immediate families (partners, children, and carers). The Australian Government partly agreed to expand eligibility to VVCS to include all current and former permanent members of the ADF through White Card arrangements and to include certain family groups.[66] The 2017-18 budget included expansion of eligibility access to VVCS:

> Any partner, dependant or immediate family member will have access to the services and support provided by VVCS, including counselling and group programs. Former partners of ADF personnel will also be able to access VVCS up to five years after a couple separates or while co-parenting a child under the age of 18.[67]

Operation Life

3.57 DVA's Operation *Life* initiative aims to prevent suicide and promote mental health and resilience across the veteran community. It is intended to provide veterans and their families with the tools to recognise and act on suicidal tendencies in the early stages. It includes website resources, a companion app and workshops run by the VVCS to 'increase the ex-service community's awareness of, and ability to respond to, suicidal behaviour in individuals'. The VVCS workshops included;

- safeTALK (suicide alertness for everyone) – a half-day presentation;
- ASIST (Applied Suicide Intervention Skills Training) – 2-day skills training; and
- ASIST Tune-up (Applied Suicide Intervention Skills Training Tune-Up) – a half-day refresher workshop.[68]

3.58 DVA noted the 2016-17 Budget included $1 million over four years for the Veteran Suicide Awareness and Prevention Programs for the continuation of Operation *Life*.[69]

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65 *Submission 156*, pp 7-8.

66 Government response to Senate Foreign Affairs, Defence and Trade References Committee report, *Mental health of Australian Defence Force members and veterans*, September 2016, pp 10-11.

67 *Budget 2017-18, Portfolio Budget Statement, Budget Related Paper No. 1.4B*, p. 16.

68 *Submission 156*, p. 9.

Non-liability health care – mental health conditions

3.59 The Budget 2017-18 included funding of $33.5 million over four years to provide treatment for all mental health conditions under non-liability health care arrangements. This built on the previous initiative which allowed all current and former members of the ADF who had served one day in the full-time ADF to be able to access treatment for the specific common mental health conditions such as PTSD. The new initiative was expected to benefit around 2,000 current and former ADF members and would include coverage for adjustment disorders, acute stress disorder, phobias, panic disorder, agoraphobia, and bipolar and related disorders.[70]

> Treatment under the non-liability health care arrangements is delivered through the provision of a DVA White Card. Services available under these arrangements may include general practitioner, psychiatrist, psychologist, medication, public or private hospital, and counselling.[71]

3.60 DVA officials also noted that the expansion of non-liability health care had been well received. Mr Luke Brown, Assistant Secretary, Policy Support Branch from DVA told the committee that in the 2016 calendar year for non-liability health care for mental health conditions, DVA had 8,049 successful claims, which was a 55 per cent increase on last calendar year.[72] The estimated cost of mental health treatment used in the costing of the 2017-18 Budget measure to expand treatment to all mental health conditions under non-liability health care arrangements was $4,500 per patient per annum.[73]

Pilot studies

3.61 A number of pilot studies and programs related to suicide prevention have recently been announced. On 11 August 2016, the Australian Government announced a suicide prevention trial site would be established in North Queensland. Minister Tehan outlined:

> This will occur through the North Queensland Primary Health Network. As part of its work, the trial will focus on veterans' mental health. This will be one of 12 innovative, front-line trials in our fight against suicide which will improve understanding of the challenges and work to develop best-practice services which we can be applied nationwide.[74]

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69 *Submission 156*, p. 9.

70 DVA, 'Mental health treatment for current and former members of the Australian Defence Force – expanded access', *Budget 2017-18*, p. 1.

71 DVA, 'Mental health treatment for current and former members of the Australian Defence Force – expanded access', *Budget 2017-18*, p. 1.

72 *Committee Hansard*, 6 February 2017, p. 64.

73 DVA, response to question on notice 9, Budget estimates, 30 May 2017, p. 1.

74 The Hon Dan Tehan MP, Minister for Veterans' Affairs, 'Government supports veterans and ADF personnel', *Media release*, 11 August 2016.

3.62 The 2017-18 Budget included funding of $9.8 million over three years to pilot two new approaches to supporting vulnerable veterans experiencing mental health concerns. DVA stated:

> The two suicide prevention pilots announced in this year's Budget are specific mental health treatment interventions, which will support vulnerable veterans with complex acute or chronic mental health conditions. The first pilot, the Mental Health Clinical Management Pilot, will be delivered to an at-risk population with complex mental health needs on discharge from a mental health hospital. These participants will be at risk of self-harm, re-admission and/or homelessness. The second pilot, the Coordinated Veterans' Care (CVC) Mental Health Pilot, will be targeted at patients with chronic mental and physical health comorbidities, who require clinical management through general practice and, where necessary, other mental health professionals.[75]

3.63 Over the two years of the pilot programs, up to 100 veterans will participate in the Mental Health Clinical Management Pilot, and up to 250 veterans will participate in the expansion of the Coordinated Veterans' Care (CVC) program.[76] In relation to the CVC pilot, DVA provided information from an evaluation which indicated that 'although expected savings are yet to be achieved, there is evidence to suggest that these could arise with longer term program enrolments' and there were 'positive qualitative benefits' based on feedback by veterans and General Practitioners.[77]

Mental health assistance

3.64 Access to mental health services by veterans was perceived as a critical component in suicide prevention. Many submitters noted the relationship between incidence of mental illness and rates of suicide. In particular, they identified veterans with mental illness as being an 'at risk cohort'.[78] The AISRP noted:

> The Mental Health Prevalence and Wellbeing Study (MHPW) found that more than half of the ADF population sampled had experienced mental illness in their lifetime, significantly higher compared to the general population, despite the "healthy worker effect" (those selected into the military are screened for mental illness prior to entry, creating a more healthy population). In March 2015, DVA reported it was supporting 147,318 veterans, with 49,668 of these having accepted mental disorders.[79]

3.65 Phoenix Australia also observed that the 2010 MHPW study indicated that 90 per cent of those reporting suicidal ideation had a mental health condition. Accordingly, it considered it was important 'to address the quality of mental health

75 DVA, response to question on notice 10, Budget estimates, 30 May 2017, p. 1.

76 DVA, 'Suicide prevention pilots', *Budget 2017-18*, p. 1.

77 DVA, response to question on notice 15, Budget estimates, 30 May 2017, p. 1.

78 For example, VVFA, *Submission 277*, p. 8.

79 *Submission 174*, p. 2.

treatment available to veterans, and improve the service system that delivers treatment, in order to address this risk factor and reduce the rate of suicide'.[80]

Lack of expertise in treating veterans

3.66 It was highlighted that the ADF only employed one full-time psychiatrist at the ADF Centre for Mental Health.[81] Dr Jonathan Lane, a consultant psychiatrist, considered:

> This has the unfortunate consequence that there is not a body of clinicians who actually have a significant amount of experience working with the military, full stop, let alone working with veterans. There are no formal training pathways for military psychiatry or for dealing with veterans, so it is a very under-utilised and under-resourced area in the clinical expertise that clinicians have when they are dealing with veterans.
>
> I think this leads to the estrangement of veterans when they actually have left the military and when they are trying to access services in the civilian community.[82]

3.67 Dr Lane also noted that there was 'no training for psychiatrists during medical school or during your training period as a psychiatrist in military psychiatry or in veterans culture and community'.[83] Similarly, Dr Khoo observed that 'there are a lot of my colleagues who provide reports who would not have a clue about military medicine, military culture or what happens to a soldier after they are deployed and after they are discharged'.[84]

3.68 This point was also echoed by veterans and ESOs. For example, the William Kibby VC Veterans' Shed noted a previous proposal that 'both men and women exiting the ADF be offered placements at various universities around Australia, to study medicine, the view to branching to either studying Psychiatry or Psychology'. It stated:

> This idea was brought up because of the extreme shortage of both Psychiatrists and Psychologists with an ADF background.
>
> All too often we at the Veterans' Shed have heard the comments of "how would they know, they weren't there", which translated means how can someone without an operational experience treat someone who has seen operational service?[85]

3.69 Defence specific training for clinicians was available through online courses offered by DVA and training programs offered by the Phoenix Australia.[86] DVA

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80 *Submission 177*, p. 2.

81 *Committee Hansard*, 17 November 2016, p. 21.

82 *Committee Hansard*, 17 November 2016, p. 16.

83 *Committee Hansard*, 17 November 2016, p. 17.

84 *Committee Hansard*, 2 February 2017, p. 15.

85 *Submission 97*, p. 4.

86 For example, Dr Katelyn Kerr, *Committee Hansard*, 2 February 2017, p. 8.

noted there were six e-learning programs for mental health practitioners that were available through the *At Ease* portal. These were:

- vetAWARE;
- Understanding the Military Experience;
- Case Formulation;
- Working with Veterans with Mental Health Problems (GP specific);
- PTSD - Psychological Interventions Program; and
- the VVCS Practitioners Guide.[87]

3.70 In addition to these resources, DVA outlined that it 'provides a research dissemination website, known as Evidence Compass, an on line version of an assessment tool, *ADF Post-discharge GP Health Assessment,…Mental Health Advice Book and Beyond The Call: stories from veterans and their families'*.[88]

3.71 The Australian Psychological Society thought that the 'current DVA suite of eLearning online training such as 'understanding the military experience' modules are important in building a cohort of providers informed in the military experience'. However it noted:

> [T]here is no requirement for DVA providers to undertake this training and there are currently no incentives for health practitioners to complete the training. Additionally, there is no mechanism for referrers or consumers to identify service providers who have undertaken the DVA training.
>
> This gap could be remediated by (a) introducing enhanced comprehensive training for service providers delivering mental health services to this cohort; this could comprise a series of linked modules that include an assessment component and evidence of completion and would provide an indication of basic competencies (Practice Certificate), (b) implementing a system for identifying who has undertaken the training, and (c) introducing incentives for undertaking the training and demonstrating outcomes in clinical practice.[89]

3.72 Similarly, Mates4Mates argued that '[c]linicians who treat veterans need to also have astrong understanding of the military context from which the veteran has originated'. It suggested:

> To instill confidence in veterans it would be useful if there was a way for them to know which provider has completed the DVA training modules. This will provide veterans with a level of confidence that these service providers have an understanding of their unique situation – this will help

87 *Submission 156*, p. 11.

88 *Submission 156*, p. 11.

89 *Submission 42*, p. 1.

> with the development of a strong therapeutic relationship and means the veteran will hopefully be in a better position to continue to seek support.[90]

3.73 The AISRP commented that '[w]orking with current and ex-serving members requires a unique and specialised skill set incorporating intimate knowledge of their work experiences, demands, organisational culture, and traumas'. Many mental health clinicians feel under-skilled or unprepared for working with veterans, and therefore choose not to see this client group. It observed:

> DVA provides online training to up-skill practitioners, however there are no incentives for clinicians to undertake this training, and eLearning only suits those comfortable with that learning style. DVA could introduce face-to-face training for clinicians to increase confidence and skills and provide remuneration for this, which would increase the number of experienced and high quality professionals working with veterans.[91]

3.74 The NMHC report recommended further enhancement of specialist mental health expertise within the ADF. This could include 'a greater number of military psychiatrists, engagement of mental health nurse practitioners, and more allied health practitioners with clinical mental health expertise'. The NMHC suggested the cost of this enhancement could be off-set by reducing outsourced mental health specialist services.[92] In relation to this issue, Defence emphasised that the Defence White Paper included engagement of additional permanent ADF specialist mental health personnel:

> This initiative will expand the Medical Specialist Program to include the specialty of psychiatry through an additional seven specialist psychiatrist or trainee registrar positions. This will form the core of ongoing reform of delivery of specialist mental health services to deployable, deployed and returned ADF personnel.[93]

3.75 The NMHC also proposed that consideration be given to 'funding and developing further specialist mental health centres of excellence within all major defence service regions, providing local capability and knowledge as well as the opportunity to form partnerships and build the evidence base through high quality research and service evaluation'. It stated:

> Such centres would see consultant psychiatrists working within specialist multi-disciplinary teams which include mental health nurses, allied health practitioners and peer workers, and could potentially offer services to current and former serving personnel, and their families.[94]

3.76 The Australian Government response noted that 'Defence has a number of current actions in place to expand specialist mental health expertise within Defence

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90 *Submission 173*, p. 2.

91 *Submission 174*, p. 3.

92 NMHC report, p. 54.

93 *Submission 124*, p. 15.

94 NMHC report, p. 54.

Health Services supported by an expansion of the role of the ADF Centre for Mental Health'. It stated:

> Defence has a proposal to expand the existing ADF Centre for Mental Health as the centre of excellence within Defence, to create a bespoke model for supporting access to clinical expertise across Defence regional health services and develop partnerships with other external national centres of excellence.
>
> As part of the 2016 Election commitments, the Government committed to providing $6 million over four years from 2016-17 to develop the Centenary of Anzac Centre in partnership with Phoenix Australia. The Centre will perform two primary functions, of providing practitioner support and treatment research.[95]

Fees

3.77 During the inquiry into the mental health of ADF serving personnel, the committee raised concerns regarding the evidence that psychologists are unwilling or unable to treat veterans due to DVA providing inadequate funding for psychological services. The committee noted that there is a significant gap between the DVA schedule of fees and the Australian Psychological Society's schedule of recommended fees. The committee raised concerns that inadequate funding of psychological services would limit the already scarce mental health services available to veterans (especially those living in regional or remote areas).

3.78 The committee recommended that the DVA Psychologists Schedule of Fees be revised to better reflect the Australian Psychological Societies' National Schedule of Recommended Fees, and that any restrictions regarding the number of hours or frequency of psychologist sessions are based on achieving the best outcome and guaranteeing the safety of the veteran.[96]

3.79 These concerns during the gaps in fees paid by DVA and access to specialist care were repeated during the current inquiry. The Australian Psychological Society commented:

> At the present time, there is a freeze on the DVA Psychology Schedule of Fees. This freeze dates back to 2014 and acts as a disincentive for the uptake of skilled clinicians. Unlike other existing mental health services for civilians (e.g. Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative), there is no capacity to charge a co-payment for DVA services. This inability to strike a fee that reflects the practitioner's expertise and the typically complex needs of ex-serving personnel and veterans is an operational disincentive to the uptake of such work by practitioners who would otherwise be willing and suited to it.[97]

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95 Government response to the NMHC report, p. 70.

96 Senate Foreign Affairs, Defence and Trade References Committee, *Mental health of Australian Defence Force members and veterans*, March 2016, p. 90.

97 *Submission 42*, p. 2.

3.80 The AISRP also commented on this 'large discrepancy' between the fee charged to private civilian clients and 'that which DVA pays; which was creating a disincentive for experienced and skilled clinicians to see veterans:

> If DVA would match the fee schedule provided by Medibank Health Solutions or that recommended by the APS, this would increase the number of psychologists willing to see veterans and would increase the delivery of gold-standard interventions which have high success rates in treating mental disorders. Many veterans report receiving pharmacological treatment, but are not receiving psychological treatment which is the gold-standard because it is highly effective in creating many disorders commonly experienced by veterans (eg. PTSD, depression, anxiety, substance use disorders).[98]

3.81 When questioned on this issue, Ms Sue Campion, First Assistant Secretary, Health and Community Services with DVA stated:

> The difference is that generally our health services are based on the MBS and PBS and other things, and then we add to them. So in the case of the MBS and fees, we pay the MBS fee plus an additional percentage to reflect the fact that our fees represent the full payment for service, so there is no patient contribution. Defence's model is that they have purchased the provision of health services through, in this current instance, Medibank, but they are not referencing necessarily to the MBS rates. They have negotiated a separate contract for the provision of their services, whereas we rely on the general universal access health system and then add to it.[99]

3.82 DVA acknowledged evidence provided to the committee about psychiatrists and psychologists not accepting DVA fee arrangements or withdrawing from these arrangements. However, it considered it was not possible 'to discern trends from the data about the extent of provider participation in DVA arrangements'.[100] It stated:

> In the event that a practitioner may not accept DVA fees or there are no providers, DVA provides assistance in identifying another suitable practitioner, providing transport assistance, or considering a provider's request to fund services above DVA fees. An 'above fee' request is determined on the basis of clinical need, and includes consideration of the patient's ability to reasonably access another suitable practitioner. [101]

3.83 DVA argued it was not possible to directly compare Defence fees with those of DVA. It noted that on base health services provided to currently serving members 'are delivered by a mixed workforce of ADF, APS and contractors, inclusive of mental health professionals'. The on-base contractor health workforce is provided under the contract with Medibank Health Solutions. In contrast, DVA arrangements for medical

98 *Submission 174*, p. 4.

99 *Committee Hansard*, 6 February 2017, p. 61.

100 DVA, response to question on notice from hearing 6 February 2017.

101 DVA, response to question on notice from hearing 6 February 2017.

services, including psychiatry are aligned to Medicare although it highlighted that DVA fees are set at a higher rate than comparable Medicare fees.[102] It outlined:

> DVA psychiatry consultations are paid at 135 percent of the equivalent Medicare fee, with a psychiatrist consultation of between 45 minutes and 75 minutes currently $247.95 under DVA and rebated under Medicare at $156.15 (which is 85 per cent of the Medicare fee).
>
> In 2010 when DVA introduced individual fee schedules for each allied mental health profession, the fees reflected the MBS-equivalent time based items and were paid at 100% of the MBS rate, as part of a package negotiated with the relevant provider associations at the time.
>
> Under current DVA arrangements for clinical psychology, a consultation lasting 50 minutes or more attracts a fee of $148.95 where the equivalent is rebated under Medicare for $124.50 (which is 85 percent of the Medicare fee of $146.45). The indexation of the DVA fees has been paused since November 2014, with the pause to continue until 30 June 2018.[103]

Model of care

3.84 The most effective model for mental health services to support veterans and the need for veteran-specific services was also discussed during the inquiry. The relevance of this issue was illustrated by the planned closure of the Repatriation General Hospital in Adelaide at the end of 2017 and the movement of services to the Jamie Larcombe Centre at Glenside Health Service Campus. The South Australian Government outlined that this new $15 million facility was intended to be a '[post-traumatic stress] Centre of Excellence in recognition of the potential impact of military service on the mental health of service and ex-service personnel':

> The new facility will be purpose built and will incorporate an acute 24 bed inpatient unit, outpatient services, teaching and research spaces…It is envisaged that the Precinct will provide comprehensive, trusted and person centred, family orientated veteran mental health services.
>
> In the context of the new Veterans Mental Health Precinct, it has been timely to review the Model of Care for specialist mental health services for veterans. Clinicians, managers, consumers, carers and emergency service personnel are engaging in the process and contributing to the Model of Care that will incorporate innovation, is shaped by evidence based practice, and defined by standards of care to address the mental health care needs of veterans and emergency service personnel. Research is seen as a critical element to ensure the Model of Care is flexible and able to identify the most appropriate treatment options.[104]

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102 DVA, response to question on notice from hearing 6 February 2017.

103 DVA, response to question on notice from hearing 6 February 2017.

104 *Submission 187*, pp 3-4.

3.85 There were perceived advantages in services for veterans being co-located and veterans being able to receive treatment together. For example, Mr Guy Bowering told the committee about his experiences in Ward 17 at the Repatriation General Hospital:

> The crash and burn of my PTSD experience within the Repatriation General Hospital also allowed my other comorbidities to be taken care of all in one place. No-one I met within Ward 17 had just PTSD; they had things like sleep problems, gastrointestinal problems, diabetes, chronic pain et cetera. All these were taken care of on one site…Military and veteran mental health is not a cookie-cutter version of a normal mental health facility. It acknowledges the peculiar service and stresses that we put on our military members, and the treatment is tailored with that in mind. Ward 17 cannot exist as a standalone facility. It requires the support of facilities that only a hospital campus like the Repatriation General Hospital can supply. With the move, current ADF members and veterans will receive a degraded service.[105]

3.86 RANZCP noted that as specialist services, veteran hospitals provide a number of advantages. These included:

- specialist staff across a range of health domains, including psychiatry, representing consolidated clinical knowledge passed down through generations of specialist training and 'on-the-job' experience;
- evolving models of care attendant to changing needs based on clinical observation and assessment, consolidation of knowledge and innovation of services;
- assured service provision with continuity of care; and
- improved advocacy and understanding of system deficiencies facilitated by structured communication lines between veterans and community members, health professionals and departmental management.

3.87 The RANZCP commented that without the concentration of expertise engendered by a system of veteran-specific hospitals, health care is provided to veterans according to the purchaser-provider model, requiring them to source their own service. It noted this could lead to fragmented services offering models of care at varying levels of quality with no guaranteed continuity of care. It was aware of veterans which had found sourcing of appropriate care difficult.[106]

3.88 The RSL observed that the purchaser provider model is 'very much focused on the provision of funding for consultations and episodes of care'.

> It takes little overarching analysis of the different requirements of patients with different levels of acuity. There needs to be a system that has secondary and tertiary referral services for those who are not responding to the primary evidence-based treatments. The access to the higher acuity levels of care for veterans needs to be audited.

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105 *Committee Hansard*, 17 November 2016, p. 39.

106 *Submission 156*, p. 10.

> As veterans hospitals substantially no longer exist, the priority care for veterans is more difficult to deliver. Much of the care, particularly when the very unwell, is now provided within the state systems. We know that these are underfunded and often individuals who represent a significant suicide risk are turned away. They have little expertise in trauma-related psychopathology and are not likely to deal well with the types of needs a veteran is likely to present.[107]

3.89 Another key concern was enabling choice by veterans in relation to mental health services. For example, DefenceCare RSL considered that DVA's services were 'prescriptive and based on clinical-only treatment' leaving veterans with 'little say in the allocation of funding to clinical or non-clinical treatments or aids that they believe are important to their particular circumstances'. It recommended investigation and a trial of a model of consumer directed care (CDC) for veterans:

> CDC empowers the consumer to have more control over their life and be in charge of decisions about their lifestyle and support. It focuses on the person's life goals and strengths, placing their needs at the centre of the services and support. The person makes choices and/or manages the services they access, to the extent they can and wish to do so, including who will deliver services and when.[108]

3.90 The Australian Psychological Society commended DVA's work over the last decade to review and improve 'the range of funded inpatient, outpatient, teleconferencing and online services for veterans'. However, it noted that there was evidence that 'current service models do not effectively reach a large number of veterans' and this particularly disadvantaged veterans in rural and remote areas and veterans with physical disabilities. It suggested a 'hub and spoke model of service delivery could improve access for many of these veterans'. It stated:

3.91 The NMHC report advised Defence and DVA to 'continue to build on the stepped mental health care model in place and ensure that a range of early intervention options are available that can maximise early help-seeking and minimise the impact that mental illness may have (e.g. on career progression or deployment or post-military employment)'.[109] The Government's response to the NMHC report noted that the Department of Health through primary health networks and national programs was increasing the availability of low intensity services including digital services which would be able to support both current and former members of the ADF. In particular, these digital services, including the $30M investment in the Synergy IT, would respond to 'the help-seeking behaviours of at-risk young men'.[110]

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107 *Submission 216*, p. 2.

108 *Submission 216*, pp 17-18.

109 NMHC report, p. 53.

110 Government response to NMHC report, p. 70.

Conclusion and recommendations

3.92 Suicide by veterans is particularly disturbing due to a recognised collective responsibility for the welfare of those who have rendered service on behalf of the community. Further, ADF members are a healthy and resilient group, who benefit from high-quality support while in uniform. In this context, there are understandable concerns that the suicide rate for the veteran community is not significantly lower than the general population.

3.93 The reasons why a person may decide to take their own life can be very complex. In particular, not everyone who has suicidal ideation has a mental health condition. The evidence received covered a range of factors which might contribute to veterans and ex-service personnel taking their own lives. Research in this area is still continuing and at this stage it is difficult to discern any clear trend or common factor. To the committee, this indicates that the current preventative, early intervention model targeted to those at risk, together with a holistic response to improve the overall welfare of veterans is the most appropriate approach to reduce the rate of suicide amongst veterans.

3.94 The NMHC report recommended addressing the needs of younger veterans following the release of the first AIHW results which identified this cohort as a vulnerable group. The NMHC urged 'as a matter of priority' that the Minister of Veterans' Affairs liaise with the Minister for Health 'to oversee the development of strategies, utilising a co-design process, to engage and support former members of the ADF aged 18-29 years, who have left the service in the last 5 years and who could be at risk of suicide or self-harm'.[111] The Government response outlined several initiatives directed to this age group. These included:

> The Government recently allocated $30 million to develop digital mental health initiatives as part of Project Synergy, including an internet-based platform for mental health tools primarily targeted at young people. As part of this investment, a trial with VVCS clients will be conducted…
>
> The Australian Government funds the headspace network, which provides free or low cost access to youth specific mental health services for young people aged 12-25 years. headspace services are also available to young veterans, defence personnel and their families across Australia. headspace takes a holistic approach to mental health by also providing support for related physical health, drug and alcohol problems, and social and vocational support. Where headspace is not the best service for a young person, headspace will use established clinical pathways to connect young people to appropriate services.
>
> Government is partnering with Lifeline Australia to support the $2.5 million trial of a new crisis text service, Text4Good, for all Australians in need.[112]

111 NMHC report, p. 53.

112 Government response to NMHC report, p. 68.

3.95 In the view of the committee, there is more that can be done to respond to these new research findings. The recent AIHW research findings concerning at risk groups based on their age, discharge and service characteristics should be used to develop new targeted suicide prevention and veteran support programs. Additional targeted programs to these at-risk veterans could yield long-term improvements in the health and welfare outcomes as well as contributing to reducing the incidence of suicide and self-harm.

3.96 In particular, DVA has already outlined to the committee the positive results achieved by the *DVA Reconnects* project which aims to reconnect with clients through proactive contact attempts and the provision of a complex and multiple needs assessment.[113] DVA (with the assistance of with Defence) should be matching the information they have about recent veterans with these identified 'at-risk' characteristics. Where DVA identifies veterans who have these at-risk characteristics, DVA should be proactively seeking to contact these veterans to ensure that they are aware of the supports available to them.

Recommendation 1

3.97 The committee recommends, that in the context of recent Australian Institute of Health and Welfare findings concerning veterans at risk of suicide, the Australian Government:

- **develop and implement specific suicide prevention programs targeted at those veterans identified in at-risk groups; and**
- **expand the DVA Reconnects Project to proactively contact veterans in these identified in at-risk groups.**

3.98 A large number of submissions from veterans focussed on the issues confronting them due to the complex legislative framework of veterans' entitlements and its administration by DVA. Problems with the compensation claims process were often perceived as key stressors and contributing factors to suicide by some veterans. Further consideration of improvements in these areas will be addressed in the next chapters. However, in the view of the committee, there is a lack of research in this specific area. In particular, the impact of DVA claim assessment processes as a stressor on veterans and their families.[114] On the evidence received, the committee considers this topic merits an independent investigation. The results of this study should be used to improve and restructure DVA assessment processes to reduce the stress for veterans and improve overall outcomes.

Recommendation 2

3.99 The committee recommends that the Australian Government commission an independent study into the mental health impacts of compensation claim assessment processes on veterans engaging with the Department of Veterans'

113 *Submission 156*, p. 15. See discussion in Chapter 6.

114 For example, Dr Katelyn Kerr, *Committee Hansard*, 2 February 2017, p. 3.

Affairs and the Commonwealth Superannuation Corporation. The results of this research should be utilised to improve compensation claim processes.

3.100 The committee welcomes the valuable investment of DVA and Defence in the Transition and Wellbeing Research Programme and other research initiatives. The AISRP report has highlighted that research into veteran suicide carried out in other countries cannot necessarily be applied to Australia. Further, ongoing research will be needed. The committee notes that DVA and Defence are currently in discussions with AIHW to continue and regularly update its work on the incidence of veteran suicide. Building on this recent valuable study, there needs to be consideration regarding the establishment of a permanent National Veteran Suicide Register based on the model of the Queensland Suicide Register (QSR).

3.101 The QSR works with police and the coronial system to gather more detailed data on deaths by suicide that occur in that jurisdiction. While the broad direction of the suicide rate amongst veterans will be useful in determining the extent of the issue and to track change, there is a range of other significant information that could be collected to inform policy approaches in the future. The creation of an official publicly funded register may also serve to allay concerns raised that unofficial registers could sensationalise the topic of veteran suicide and have other negative consequences.

Recommendation 3

3.102 The committee recommends that the Australian Government establish a National Veteran Suicide Register to be maintained by the Australian Institute of Health and Welfare.

3.103 The committee was concerned by evidence regarding a lack of psychiatric expertise within Defence. However, Defence has indicated it is improving mental health care and support for ADF members, including through the 'engagement of an additional six specialist psychiatric trainees and specialists as well as one administrative coordinator'.[115] The lack of experience in treating veteran-specific issues within the Australian professional mental health community was also troubling. The Australian Psychological Society made a number of proposals to enhance the online training to practitioners provided of DVA. In the view of the committee, these proposals deserve departmental consideration.

Recommendation 4

3.104 The committee recommends that the Australian Government review the enhancement of veteran-specific online training programs intended for mental health professionals. In particular:

- **requirements for providers to undertake training;**
- **the introduction of incentives for undertaking online training and demonstrating outcomes in clinical practice.**

115 Government response to the NMHC report, p. 15.

3.105 The committee was concerned that discrepancies between the fees paid by Defence and DVA continue to be identified as a barrier to veterans accessing professional mental health services. In order to ensure seamless care is provided to both serving ADF members and veterans, the committee considers that these arrangements for the provision of mental health care should be aligned. In particular, there should be no difference in the fee paid to a mental health professional by Defence or DVA regardless of whether the patient is a serving ADF member or a veteran.

Recommendation 5

3.106 The committee recommends that Defence and the Department of Veterans' Affairs align arrangements for the provision of professional mental health care.

3.107 During the inquiry, committee members expressed concern with the progress of the suicide prevention trial for Townsville. In May 2017, it was announced that a Veteran Suicide Prevention Project Manager had been appointed.[116] While the committee understands this project is being led the North Queensland Primary Health Network, the committee urges the Australian Government to work to expedite implementation and assessment of this trial which has the potential to be an important model for support services in other parts of Australia.

116 Northern Queensland Primary Health Network, 'Townsville veteran suicide role appointed', Media release, 9 May 2017, available at https://www.votsa.org.au/images/News/NQPHN/NQPHN_Media_Release.pdf (accessed 17 July 2017).