

# **Review into the Suicide and Self-Harm Prevention Services Available to current and former serving ADF members and their families**

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Final report: Findings and Recommendations

National Mental Health Commission

28 March 2017

## **Acknowledgement**

We acknowledge people with a lived experience of suicide and mental health issues, their families, friends and supporters. We acknowledge all who provided input into this Review process, including current and former serving members of the Australian Defence Force and their families, service providers and professional organisations, the Australian Advisory Group on Suicide Prevention, and the Expert Reference Group convened for the purposes of this Review.

We also acknowledge the input received from Commonwealth agencies, including representatives from the Commonwealth Department of Health, Department of Defence and Department of Veterans' Affairs, the Australian Institute of Health and Welfare, and the Australian Bureau of Statistics.

We also acknowledge the team at ConNetica who was engaged by the National Mental Health Commission to undertake the fieldwork and data collection for this Review.

28 March 2017

Minister for Veterans' Affairs and Defence Personnel  
Minister for Health

Dear Ministers

On behalf of the National Mental Health Commission, I present to you the final report on the Review into the Suicide and Self-Harm Prevention Services available to current and former serving ADF members and their families (the Review).

This report presents the key findings against the Review's terms of reference and recommendations regarding areas for improvement and/or further investigation by Government. Separate summaries of information gathered for the Review are also available to support our findings.

I trust the findings and recommendations of this Review will contribute to the ongoing efforts by the Government and others, and ultimately lead to improvements in the lives and outcomes of current and former service men and women and their families.

Yours sincerely



Dr Peggy Brown

**CEO**

**National Mental Health Commission**



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## Executive Summary

### *What we heard*

As with all the National Mental Health Commission's work, the approach of this Review was to place current and former serving members of the Australian Defence Force (ADF), and their families, at the centre of our considerations. Through our survey, submissions, group discussions and individual interviews, we heard directly from more than 3,200 people.

While some stories pointed out instances of good practice and positive outcomes, there were many strong views presented by current and former ADF members and their families that identified areas for improvements to systems, services, beliefs and culture.

People who reported they had recently accessed mental health treatment rated their experience of services very highly. A survey conducted for the Review found that experiences were described as fair, good, very good or excellent by 80% of current ADF members and by 90% of former ADF members using health care cards to access services.

However, qualitatively, we also heard a broad range of poor experiences of services and general feelings of cynicism, distrust, frustration, abandonment and loss. For many, these are the realities of what being in the military brings and the sacrifice that is asked of them and their families in service of their country. It is not known however whether these experiences relate to recent or past experiences of the service systems. Nor is it known the extent to which these sentiments are felt across the broader estimated population of more than 700,000 current and former ADF members<sup>1</sup> and an even higher number of their family members. Nevertheless, these stories and experiences are real and deserve to be heard and responded to.

We also heard about the wide range of groups and individuals, within the government, the ADF and in the community, who are committed to driving ongoing change and improvement. These efforts will be critical to achieving improvements across a wide range of areas that are relevant to suicide, self-harm and general wellbeing, including culture, workforce, health services, training, transition and rehabilitation services.

Concerted and continued attention is needed to ensure efforts are effective in preventing suicide and self-harm amongst Australia's current and former serving personnel and their families. The Government's action in commissioning this review forms part of that effort and the National Mental Health Commission commends the Australian Government for taking the step to seek an independent review that can inform their ongoing efforts.

We would like to take this opportunity to sincerely thank everyone who provided information to this Review for your valuable contributions. We acknowledge and value your personal efforts and experiences, and support you in your resilience and commitment to recovery.

### *About our report*

Throughout the Review, the Commission has been mindful of the unique nature of military service. We have specifically endeavoured to understand and draw on the experiences and insights of current and former members of the ADF, their families, the Departments of Defence (Defence) and Veterans' Affairs (DVA) and other stakeholders with expertise in this area. This document faithfully reflects the insights and input we received as well as other materials that were available to the Commission at the time of the Review.

It should be noted that very little information was identified to inform our considerations regarding self-harm in each of the groups of interest to this Review. The findings of the Review therefore focus on suicide and the factors known to increase the risk of suicide and self-harm, including poor mental health and wellbeing.

We also found relatively little information about families of current and former serving members – their rates and risks of suicide and self-harm and their experience of services. Where possible, this report makes some observations in this regard, with an overarching finding that there is a general lack of emphasis on the critical role that families play in the lives of current and former serving members, including in relation to helping to manage risk factors for suicide and self-harm, and generally limited engagement with families by both the ADF and DVA.

While there have been many actions taken by the ADF and DVA to improve services and outcomes in relation to suicide and mental health amongst current and former serving ADF members, the context for the Review indicates that key issues persist. This is particularly reflected by two recent Senate inquiries in this space – into the *Mental Health of ADF Serving Personnel* (which tabled its report in March 2016) and more recently into *Suicide by Veterans and Ex-service Personnel* (which is expected to report by 30 March 2017). The issues raised in these inquiries should be taken into account when considering the findings and recommendations of this report.

Finally, this report should also be considered in light of two important studies being undertaken separately to this Review: the findings of the *Transition and Wellbeing Research Programme* jointly commissioned by the Departments of Defence and Veterans' Affairs, and the Australian Institute of Health and Welfare (AIHW) study *Estimation of incidence of suicide in ex-serving Australian Defence Force personnel*.

### *Our findings*

Perhaps the most striking finding from our Review was the need for ADF and DVA to work collaboratively and to ensure that their respective processes are continuous and seamless from the perspective of the current and former serving members. The insight of the Australian Government in having one Minister responsible for both Veterans' Affairs and Defence Personnel is commended in this regard and provides a solid foundation for further work to progress a unified service offering to current and former serving defence personnel and their families.

Data show that suicide rates are lower amongst current serving ADF members than in the general population, but higher for former serving ADF members, particularly those below 30 years of age.<sup>2</sup> This suggests that the population recruited for military service are at lower risk than the general population (through active selection processes) and/or that there are features of military service that protect against the risk of suicide. However, the Review also heard that some aspects of the ADF – while potentially protective during service – can contribute to increased risk of suicide and mental ill-health post-service. This appears to be particularly the case for people who are discharged unexpectedly or on the grounds of health problems.

The Review received information about a large variety of services provided by or through Defence and DVA. The Commission notes that current and former members of the ADF can also access health services that are available to the general community. However, almost no information was available about the extent to which these are accessed by current and former serving members or their families.

The Commission was presented a diverse range of experiences and perspectives about ADF and DVA services – some positive and some that were more negative – but little in the way of robust evaluative data against which to objectively assess their effectiveness. To put this statement in perspective, the same could be said for many health services in the general community.

A key area of feedback around effectiveness related to services and supports for people transitioning out of the ADF. The Commission heard that transition arrangements need to commence upon recruitment, and ensure members develop the skills they need to be participating citizens, as well as effective members of the ADF. Services and supports should be available from the point of discharge and extend for the duration of post-service life.

The Commission also heard that many former serving members feel disengaged from the ADF community following discharge, which can increase the risk of suicidal ideation and other mental health problems. Transition supports could better engage with former members to improve their access to services and to ensure the member's service is adequately recognised and acknowledged by both the ADF and the community.

The Commission heard that the experience of seeking compensation and of other administrative claims processes can be complicated and prolonged. We heard instances of increased distress and suicidal behaviour amongst those having difficulties with the claims systems, particularly amongst ADF members who are discharged against their wishes. The Commission understands that the ADF and DVA are aware of this issue and are taking steps to streamline and simplify administrative processes. Nevertheless, we note that additional efforts may also be required to help people navigate and be supported through the process.

Another issue repeatedly raised throughout the Review was whether ADF recruitment processes accurately identify and screen out people who may not be suitable for service due to mental health concerns. Resolving whether this issue is one of perception or of inadequate screening is critical, given the variety of contrasting perspectives presented on this matter, with no evidence to guide a conclusion on this matter. Resolving this issue is of critical importance, noting the higher rates of suicide for members who leave the ADF at a relatively young age<sup>3</sup>, and is an area put forward by the Commission as a priority area for further investigation.

Other key themes relating to effectiveness heard throughout the Review include the following:

- VVCS was highly praised, as was the work of individual practising on-base clinicians (psychologists and medical officers), and ADF chaplains and padres.
- Mandatory suicide prevention training and awareness courses were perceived positively by some, but by others as not particularly engaging, with feedback that they could be improved by working alongside current and former serving members and their families in the design and delivery of these courses.
- The requirement to demonstrate a significant level of disability to achieve and maintain eligibility for the Gold Card appears to create the unintended consequence of incentivising people to remain unwell, with a focus on what they can't do and what they have lost, rather than encouraging them to access services that could otherwise improve their health and wellbeing.
- Much closer and more effective engagement with families is needed to identify and respond to the particular challenges they face both in supporting current and former ADF members and in maintaining their own health and wellbeing.



- The performance of ESOs appears to vary, with feedback ranging from ESO services being helpful through to the approach of some ESOs being self-interested and in some cases harmful.

While the Commission heard little evidence regarding duplication across the range of services available, a number of service gaps were identified by reference to a stepped care framework – an increasingly recognised framework for the design of service systems in broader mental health and suicide prevention systems. In particular, for current serving members, a greater diversity of ‘step-up’ services is needed – particularly in early intervention and lower intensity on-base services to better match the service responses to people’s needs as problems emerge. Consideration could also be given to a better range of ‘step-down’ services and supports for ADF members returning to service after a period of absence related to a mental health concern or suicide attempt.

Many of the negative views regarding currently available services appeared to relate to the barriers people have faced in accessing services. This message was particularly heard from former serving ADF members, although the Commission notes that these perspectives may reflect service arrangements that have since been improved.

The strongest barrier identified by the Review is that current services responses, and attitudes and culture within parts of the ADF, can at times reinforce stigma around the experience of mental health issues and present barriers to seeking help when it is needed. Feedback to the Review also noted, however, that there is variation in the ADF cultural acceptance of mental illness and that there have been improvements in the culture in recent years. On this point, the Commission notes there is a tension within the ADF that needs to be resolved around encouraging members to seek help early (even if this is through services outside of the Defence system) and the point at which receiving help becomes a ‘need-to-know’ issue for Command from an operational perspective.

Another commonly cited barrier was a general lack of awareness of the services and supports that are available. Given the large range of services identified by the Commission in this Review, it appears that the ADF and DVA may be well served by better communication regarding the range of services available and the efforts being made by the ADF and DVA to address the incidence of and risk factors for suicide and self-harm amongst serving and ex-serving populations.

Finally, the Review heard the need for continuing efforts to evaluate services, and for better data collection systems to assist this. There is also still much unknown and hence a need for continuing investment in a research program that can support existing work that aims to prevent suicide and self-harm in current and former members of the ADF and their families. Further work to build the knowledge base of suicide rates across all age cohorts of former serving members is a priority.

### *Conclusion*

This Review has identified a number of areas for improvement to the services and systems in place to support current and former serving members of the ADF, and their families. The Commission notes that many of the findings and recommendations are not new or unique insights, but rather are issues that have been identified in previous inquiries and investigations.

The Commission acknowledges that ADF and DVA have undertaken substantial work in recent years in relation to preventing suicide, and in relation to mental health and wellbeing more broadly. Much of this work has been in response to the findings of previous inquiries and reviews, particularly the reports by Professor David Dunt in 2009, as well as through

organisational and strategic reforms (e.g. the 2016 Defence White Paper, development of DVA's veteran-centric transformation agenda).

As many of these initiatives have only recently been implemented (or are in train), their results will take some time to be known. The Commission encourages the ADF and DVA to maintain a focus on tracking progress to ensure continuous improvement to systems and services and – most importantly – to support the lives and mental health and wellbeing outcomes for current and former service men and women and their families.

## Abbreviations and Definitions

Abbreviation	Definition
ADF	Australian Defence Force
ADFA	Australian Defence Force Academy
AIHW	Australian Institute of Health and Welfare
APHRA	Australian Health Practitioner Regulation Agency
DCO	Defence Community Organisation
DVA	Department of Veterans' Affairs
ESO	Ex-Service Organisations
GHS	Garrison Health Services
JHC	Joint Health Command
POPS	Post Operational Psychological Screen
PTSD	Post-traumatic stress disorder
RtAPS	Return to Australia Psychological Screen
VVCS	Veterans and Veterans Families Counselling Service

### Key Definitions

There are several key terms to define for this report. A full glossary is included at the conclusion of the Literature Review that accompanies this report.

**Australian Defence Force (ADF):** The ADF in this Review refers to the three Services, Navy, Army and Air Force and those uniformed personnel within the Department of Defence. It includes permanent and reserve members.

**Defence:** The Defence portfolio within the Australian Government consists of a number of component organisations that together are responsible for enabling the defence of Australia and its national interests. This is the Department of Defence and ADF.

**Mental Health:** Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 2010).

**Mental (health) disorder / psychiatric disorder / mental illness:** A mental (health) disorder or psychiatric disorder or diagnosable illness characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities.

**Prevention:** A strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviours.

**Suicide risk factor:** A suicide risk factor is the presence of any factor empirically shown to correlate with suicidality, including age, sex, psychiatric diagnosis and past suicide attempts. In this report, it includes warning signs, sometimes described as proximal risk factors.

**Self-Harm, Deliberate Self-Harm (DSH) or Intentional Self-Harm (ISH):** The various methods by which individuals injure themselves, such as self-cutting, self-battering, taking overdoses or exhibiting deliberate recklessness.

**Service or Serving Personnel:** These are the permanent and reserve uniformed members within the Department of Defence and the three service arms (Navy, Army and Air Force).

**Stigma:** Stigma refers to the social disapproval of individuals or groups due to a discredited characteristic that distinguishes them from others. Corrigan (2004) and Thornicroft et al. (2007) map stigma as a problem of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination).

**Suicidal Ideation and behaviours:** A complex process that can range from suicidal thoughts, through planning of suicide, to attempting suicide and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton and van Heeringen, 2009).

**Suicide (or 'fatal suicidal behaviour'):** The act of deliberately killing oneself.<sup>4</sup> It is an act with a fatal outcome which the deceased has initiated and carried out, knowing or expecting a potentially fatal outcome (De Leo et al., 2004).

**Veterans:** Under past Australian military compensation legislation a 'veteran' is someone who has rendered 'warlike' or 'non-warlike' service (or the equivalent historical terminology) in the ADF. Under the legislative definition, therefore, a veteran could either be currently serving or have left full-time service in the ADF, which includes those who have transferred from full-time service to the reserves. For the purposes of this Review, the report uses the term 'former serving' or 'ex-serving' instead of 'veteran' to identify those who are no longer serving in the ADF.

## Terms of Reference (as at August 2016)

This Review will examine the self-harm and suicide prevention services available to current and former members of the Australian Defence Force (ADF), to assess their accessibility and effectiveness.

The primary focus of the Review will be on examining the data and evidence about the services and programmes provided by the Departments of Defence (Defence) and Veterans' Affairs (DVA). It is also acknowledged that many ex-service organisations provide a wide range of services to former serving members and their families. The Review will also give consideration to these services, particularly in the context of any gaps identified in the services provided by Defence and DVA. The Review will consider in relation to self-harm and suicide prevention:

- The range of services available to current and former serving members and their families;
- The effectiveness of these services in supporting members and their families while they serve, as they transition from Defence to civilian life, and later in their civilian life;
- Any duplication or gaps in current services and how they might be addressed;
- Any barriers to current and former serving members accessing services, taking into account cultural relevance, availability of providers, employment, functional capacity and degree of ill health;
- The extent to which former serving members utilise services provided by other parts of government, ex-service organisations, the private sector or non-government organisations; and
- The reporting of and incidence of suicide amongst serving and former serving ADF members compared to the broader Australian community.

## Conduct

The Review will be undertaken by the National Mental Health Commission (Commission), informed by experts and a reference group comprising current and former members of the ADF. The reference group will include the Chair of the Prime Ministerial Advisory Council on Veterans' Mental Health and the Deputy President of the Repatriation Commission.

The Commission will report its findings to the Minister for Veterans' Affairs and Defence Personnel, the Hon Dan Tehan MP, and the Minister for Health and Aged Care, the Hon Sussan Ley, MP.

The Review will also consider previous studies and inquiries, including the implementation of recommendations arising from these inquiries. This includes Inquiries conducted by the Senate and the study conducted by Professor David Dunt in 2009 on suicide in the ex-service community.

## Timing

A report outlining preliminary findings will be provided to Government for its consideration by 16 December 2016, with a final report to be provided to Government by 28 February 2017.

The Review will not be limited by the terms of reference and can make other recommendations for the Government to examine in relation to suicide and self-harm by serving and former serving members of the ADF.

## Introduction

### About the National Mental Health Commission

The National Mental Health Commission (the Commission) was established in 2012 by the Australian Government as an independent agency to monitor, report and provide advice on Australia's mental health and suicide prevention systems.

Our vision is that all people in Australia achieve the best possible mental wellbeing to enable them to lead contributing lives in socially and economically thriving communities. This means that every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.

To achieve this vision, our mission is to be a catalyst for change by providing insights, evidence and advice to decision makers, service providers and communities, and connecting people to lead contributing lives. This includes our role in increasing accountability and transparency in mental health through the provision of independent reports and advice to the Australian Government and the community.

In all of our work, we apply our Contributing Life framework – a whole-of-person, whole-of-system, whole-of-life approach to mental health and wellbeing, which encompasses:

- Thriving, not just surviving
- Connections with friends, family, culture and community
- Ensuring effective support, care and treatment
- Having something meaningful to do, something to look forward to
- Feeling safe, stable and secure

Consistent with the Contributing Life framework, the Commission facilitates collaboration across all sectors that help to support contributing lives and thriving communities – including health, housing, human services, income support, justice, education, employment, defence and veterans' affairs – to promote mental health and prevent suicide, integrate service provision and maximise outcomes for people and communities.

We work together with stakeholders – particularly people with lived experience of mental illness and suicide, their families and other support people – to ensure reforms are collectively owned and actioned, and that they enable participation in government process.

Our small team of dedicated staff work alongside our Commissioners, Professor Allan Fels AO (Chair), Mrs Lucinda Brogden, Professor Pat Dudgeon, Ms Jackie Crowe, Ms Nicole Gibson, Professor Ian Hickie AM, Mr Rob Knowles AO, and Dr Peggy Brown (CEO and ex-officio Commissioner)

## Context for this Review

On 11 August 2016, the National Mental Health Commission (the Commission) was tasked by the Australian Government to conduct a review of suicide and self-harm prevention services available to serving and ex-serving members of the Australian Defence Forces (ADF) and their families (the Review).

The final report was to be provided to the Minister for Veterans' Affairs and Defence Personnel and the Minister for Health and Aged Care by 28 February 2017. Following a request by the Commission, the Australian Government extended the timeframe for the Review to 28 March 2017.

Prior to this Review, there have been a number of enquiries into mental health and suicide of current and former serving members of the ADF. Principally amongst these were two reports delivered in 2009 by Professor David Dunt:

- The *Independent study into suicide in the ex-service community* (the Dunt Suicide Inquiry) considered the prevalence, risks and contributing factors for suicide and self-harm amongst ex-service members, and administrative reforms or initiatives to help combat suicide in the ex-service community. This report presented 21 recommendations (see Appendix A), all of which were accepted by the Australian Government (including one which was accepted in principle).
- The *Review of Mental Health Care in the ADF and Transition through Discharge* (the Dunt ADF Review) commended the introduction in 2002 of the ADF Mental Health Strategy but also highlighted gaps remaining in the delivery of defence mental health services. This report presented 52 recommendations (see Appendix B), all of which have subsequently been implemented.

Other recent activity that forms important context for the Commission's Review includes:

- the Senate Inquiry into the Mental Health of ADF Serving Personnel. The final report of this inquiry, tabled in March 2016, attracted some criticism that it did not consider or make specific recommendations directly in relation to self-harm or suicide.
- the Senate Inquiry into Suicide by Veterans and Ex-service Personnel. This inquiry was referred by the Senate in September 2016 and is due to report by 30 March 2017.
- media reports and perceptions in parts of the community at the time that this Review was commissioned that rates of suicide within the ADF are high and that insufficient action is being taken to address this.

Since 2009, there have been substantial programs of work underway by Defence and DVA to respond to the findings of the above inquiries and reviews. This includes specific actions to implement recommendations, which have occurred alongside broader work through both departments to progress organisational and strategic reforms (e.g. the 2016 Defence White Paper, development of DVA's veteran-centric service transformation agenda), with implications for a wide range of areas relevant to general wellbeing and the prevention of suicide and self-harm, including culture, workforce, health services, training, transition and rehabilitation services.

While there have been many actions taken by Defence and DVA to improve services and outcomes, the context for the Review indicates that key issues persist, despite the efforts made. Commissioning this Review forms part of the concerted and continued attention that is required to ensure efforts are effective in preventing suicide and self-harm amongst Australia's current and former serving personnel and their families.

## Review methodology

The Commission used a number of parallel processes to gather information to inform this Review, as follows:

- **A review of the literature** around self-harm and suicide prevention, drawing on both domestic and international research and information. This information was examined up to 1 February 2017.
- **An online survey**, which was open from 2 to 27 November 2016. A total of 2,752 survey responses was received, comprising:
  - 850 from current serving members
  - 1,662 from former serving members
  - 150 from family members of current serving members
  - 221 from family members of former serving members
  - 189 from service providers
- **34 group discussions**, held during November and December 2016, with a total of 279 individuals. Discussions were convened separately with serving ADF members (181 people), former serving ADF members (20 people), and community representatives including service provider professionals and organisations (78 people). Group discussions with family members were also planned, but did not proceed due to low response rates (11 people).
- **51 interviews with selected key informants**, including current and former personnel, support services and clinicians, academics and researchers.
- **12 supplementary in-depth interviews** with individuals who either approached the Commission or who chose this as an alternative to group discussions.
- **A public submissions process**, which was open between 2 and 27 November 2016. In total, 102 submissions were received: 38 submission documents were uploaded, and 64 submissions were received via a free-text 'comment' option embedded within the online survey. Twelve additional submissions were received from key informants and in-depth interviewees.
- **Analysis of data and documents** received from Defence, DVA and other sources (including information online and hard copy resources collected during visits to ADF bases for group discussions).

More detailed about each of these methodologies is available in the supporting documentation provided with this report. Further information is available upon request.

The Review also consulted with two key advisory groups:

- a Reference Group for the Review, appointed by the Minister for Veterans' Affairs and Defence Personnel. This group included senior officials from the ADF and the



Repatriation Commission, ex-service organisations and individual serving and former ADF members. The members of the Reference Group are listed at Appendix C.

- the Australian Advisory Group on Suicide Prevention (AAGSP). This group was established in 2016 with the primary role of providing advice, expertise and strategic support to the Commission on system-wide issues related to suicide prevention in Australia. The members of the AAGSP are listed at Appendix D.

Given the complexity and depth of information received to inform this Review, an independent review of all materials was also undertaken to ensure the robustness of the findings and recommendations contained in this report.

## Qualifiers and Limitations

Our findings are drawn from the totality of materials collected through the course of the Review and in light of the Commission's insight and experience in mental health and suicide prevention systems in the general community. Given the broad range of services delivered by ADF and DVA, and the limited information available regarding the effectiveness of those services, it was not feasible in the context of this Review to conduct a detailed assessment of individual services. The Commission has used the totality of information available to it through the course of the Review to identify the common themes, insights and experiences of those who design, deliver and receive those services.

While we have been mindful of the unique experiences and systems of military service, and specifically sought information in this regard, we acknowledge there may be areas where additional considerations may be required, given the complexities of ADF and veterans' service systems. Some areas where additional information may be useful in considering the findings and recommendations of this report are outlined below.

### *Services of the ADF*

The Commission received anecdotal information that differences between the three services of the ADF (the Navy, Army and Air Force – in terms of culture, personnel, service experience and the processes and services available – may have a bearing on suicide and self-harm. However, detailed consideration of each Service was not feasible in the context of this Review. The findings and recommendations of this report relate to the ADF as a whole.

### *Areas of limited information*

While the Commission sought information in all areas related to the Terms of Reference, there were a few areas in which only limited information was available.

Relative to suicide, little is known about self-harm, particularly amongst military populations. For this reason, the findings outlined in this report primarily relate to suicide. Some of these findings may, however, also be relevant to preventing self-harm. As noted below, the *Transition and Wellbeing Research Programme* and the targeted clinical audit into self-harm will be important to consider alongside the findings and recommendations of this review in relation to self-harm.

In relation to families, very little detailed information was available regarding their experiences of suicide, self-harm and the services they access. In addition, there were low response rates from family members to the survey and group discussions conducted for the purposes of the Review. The extent to which our findings apply families is noted throughout this report.

The Commission was limited in its ability to examine services being used outside of ADF and DVA systems. There are no identifiers that track whether service users in the general community have experience with the ADF, as current or former serving members, and information through the survey and qualitative data collected for this Review was inconclusive on this point.

The need for further information in relation to self-harm, families and service use in the community is considered throughout this report and in our recommendations.

#### *Information not considered by the Review*

The Review did not evaluate the assessment and screening tools used by Defence and its contractors, including those used for the purposes of recruitment, pre/post deployment decisions and administrative processes such as a claims assessment. As outlined above, it was not feasible to examine individual services as part of this Review. As recommended by this Review, this may be an area for further investigation by Defence.

#### *Statistical limitations*

As the number of (known) suicides in the ADF each year is relatively small, robust trends are not able to be reliably identified or generalised. This Review has therefore included a focus on the risk factors for suicide, including mental health and wellbeing.

#### *Survey limitations*

The survey undertaken for this Review did not seek information from former serving members about when they served and which (if any) deployments they were involved in. The survey results are therefore unable to analyse differences between ADF cohorts, or the impacts of their distinct experiences of military service (e.g. the Vietnam War). The survey results are also unable to distinguish whether the opinions provided relate to recent processes and services that were available to them during and following discharge from the ADF, or arrangements previously in place that may have subsequently been improved or otherwise changed.

This report includes results of the preliminary analysis of the survey data. The Commission would be happy to work with Defence and DVA to further analyse the data to identify more detailed findings.

#### *Related areas of work*

There are a number of areas of work currently underway in relation to mental health and suicide prevention amongst current and former serving ADF personnel, which may be relevant to consider alongside the findings of this report. These include the senate inquiries, noted above, the ongoing implementation by Defence and DVA of initiatives in response to the 2009 Dunt Suicide Inquiry and the 2009 Dunt ADF Review<sup>5</sup>, and work currently underway around DVA's veteran-centric transformation agenda.

Some other pieces of related work were not available to the Commission in undertaking the Review, but should be considered by Government alongside the findings and recommendations of this report.

- The Transition and Wellbeing Research Programme
  - Jointly commissioned by Defence and DVA, this programme is a major study involving thousands of serving and ex-serving personnel and their families. It examines the impact of contemporary military service on mental, physical

and social health of serving and ex-serving personnel and their families, and builds on the previous Defence research such as the Military Health Outcomes program.

- Altogether, the Programme provides a picture of mental disorders in the initial years after transition from full-time service. It also investigates how individuals previously diagnosed with a mental disorder access care; how mental health issues change over time; the mental health status of reservists and examines the experiences and needs of families of serving and ex-serving personnel.
- At the time of the Review, data analysis was underway and findings were not available for the purposes of the Review. The Commission understands that the findings will be progressively released to the Government from mid-2017.
- The Australian Institute of Health and Welfare (AIHW) study *Estimation of incidence of suicide in ex-serving Australian Defence Force personnel*
  - At the time of the Review, the full findings were not published and were therefore not available to inform the Review's considerations.
  - Preliminary results of the study were released on 30 November 2016, some of which are reported in this Review's report. However, it should be noted that the AIHW study captures information about people who were serving members in or after 2001; previously serving ADF members are not reflected in this data.
- Reports into suicide deaths within the ADF
  - Reviews into suicide attempts and deaths by suicide within the ADF have been conducted through various means of investigation internally to the ADF, including by Boards of Inquiry, Commissions of Inquiry and reviews by the Inspector General of the ADF. There are also reports that summarise the implementation of any recommendations made through these reviews. The Commission chose not to pursue access to these documents during the Review, noting the content of these reports and the need to be sensitive to the possible impacts of this information for families.
- The Commission also understands the ADF has commissioned a Case Review of self-harm by current serving ADF members. This work is using both a clinical audit tool using Defence and community standards and separate administrative audits tools for each Service of the ADF. This study was not complete at the time this Review was conducted. The Commission understands that the data set will be very small, so the insights gained are likely to be tentative and qualified at best.

The Commission notes there has been a significant volume of activity underway relating to suicide and self-harm in current and former members of the ADF, and that this may have limited the Review's ability to engage with ADF and veterans populations.

- The Commission is aware of confusion that has been voiced around how the present Review's objectives and activities are distinct from other reviews and inquiries.

- ADF and veteran communities have participated in a number of studies and surveys in recent years, meaning that potential respondents to the Review’s work may have been experiencing ‘survey fatigue’. In designing the Review, care was taken where possible to ensure data collection complemented other studies (especially the *Transition and Wellbeing Research Programme*).

The Commission advises that the findings and recommendations made in this report be considered in light of emerging evidence, particularly the outcomes of the *Transition and Wellbeing Research Programme* and the final report from the AIHW noted above.

### **Structure of this report**

The Commission’s final report for the Review comprises this document on Findings and Recommendations, plus a number of supporting reports which document detailed findings from the various research methodologies undertaken through this Review. Those supporting documents are as follows:

1. Literature Review
2. Surveys – Preliminary Results
3. Submissions
4. Key Informants
5. Group Discussions
6. Review of ADF and DVA Documentation

## Overview of findings

### About suicide and self-harm

The terms of reference for this Review refer to both suicide and self-harm. It is important to understand that these are distinct phenomena and are not always related. The following definitions have been adopted for the purposes of this Review:

- Suicide is the act of deliberately killing oneself. It is an act with a fatal outcome, which the deceased has initiated and carried out, knowing or expecting a potentially fatal outcome.
- Self-harm refers to the various methods by which individuals injure themselves, such as self-cutting, self-battering, taking overdoses or exhibiting deliberate recklessness. Intentional self-harm is deliberate injury to the body without suicidal intent.

The risk factors for suicide and for self-harm are complex and varied, and can be related to individual, social and contextual factors. However, there is no clear 'checklist' to determine whether a person is likely to attempt or die by suicide, or engage in self-harming behaviour.

Self-harm is regarded as a risk factor for suicide: that is, a person who has harmed himself or herself would be regarded as having an elevated risk of suicide. However, self-harm is not always a step on the path to suicide; similarly, a person does not need to have first attempted self-harm before they are considered to be at risk of suicide.

Despite decades of research, the pathways to suicide and self-harm are only partially explained by models of behaviour. Suicide and self-harm is intensely personal, and while numerous risk factors have been identified, the constellations of these factors and an individual's personal vulnerability and characteristics increase complexity. For similar reasons, few studies can identify strong protective factors regarding suicide and self-harm.

However, suicide and self-harm can be prevented and what is known must be acted upon. There are clear links between suicide and mental illness, social connection and access to and effectiveness of care. Stigma around mental illness and suicide is also a strong risk factor. A broader understanding of mental wellbeing, resilience and social connection affords stronger evidence of the protective factors relevant to suicide and self-harm.

In terms of specific strategies for preventing suicide and self-harm, most of the available research focuses on people with existing psychological disorders rather than the broader population. Nevertheless, there are lessons that can be learned. For instance, in a study of 41 suicide prevention strategies, the three most effective strategies implemented included limiting access to lethal means, the continuation of contact with persons discharged from an acute mental health unit and implementation of emergency call centres.

The research indicates that the majority of prevention efforts use only one or a small number of limited research strategies, and many do not employ sufficiently robust evaluation methodologies. Tracking the results of the Australian Government's 12 new suicide prevention trial sites – including in North Queensland, where there is a large military population – will be an important contribution in this regard.

## What distinguishes military service from other experiences?

The total size of the population of Australians who are serving or have previously served in the ADF is estimated to be around 710,000.<sup>6</sup>

- As at 30 June 2016, there were 79,493 current serving ADF members, 58,035 of whom are permanent members, with the balance made up of reservists.<sup>7</sup>
- Among former-serving members and families, data is only available for those who are in contact with DVA. As at September 2016, DVA supported a total of 299,655 clients, some through health treatment card entitlements (with 198,073 people holding a Gold or White Card, comprising 125,599 former serving members and 68,858 dependents) and some through other benefits, services and processes (such as pensions or compensation claims).

There are no reliable figures that the Commission was made aware of around the total number of family members of current and former serving members of the ADF.

There are a number of factors that differentiate current and former serving ADF personnel from the general population in terms of the risks of suicide and self-harm.

The ADF population is specifically recruited and trained to be strong, tough, resilient and perseverant in the face of adversity.<sup>8</sup> In the context of active service, these are traits that are desirable and indeed essential. However, these same traits can present challenges in a civilian context, including in the management and prevention of mental illness, self-harm and suicidal ideation.

For current serving members, there are a number of protective factors that are likely to reduce the risk of suicide whilst serving compared with the general population. For example, serving members have access to a range of medical services which, in many cases, are arguably better than those available to the general population. Within the ADF there is also a strong sense of camaraderie, purpose and belonging, which are all seen to be strong preventative factors against suicide.

Some aspects of military life can be protective factors in some circumstances and risk factors in others. For example, the ADF is a highly structured and regimented institution in which serving members have access to a wide array of supporting services and benefits, such as on-base medical and dental care, access to specialist medical services off-base, housing and other accommodation, meals etc. These are all seen to be part of the array of protective factors that are associated with serving in the ADF. However, it is also argued this array of support services may encourage a degree of dependency and poor development of 'life skills', which may be potentially harmful when service personnel transition to civilian life.

Other risk factors for serving and former ADF members that could potentially elevate the risk of suicide include:

- Separation from the ADF – the act of leaving the ADF itself can for some be a significant risk factor for suicide and self-harm, given the loss of identity, purpose and social connections it can lead to. These impacts might be exacerbated in some circumstances where the separation is involuntary (e.g. for medical or disciplinary reasons).
- Adjusting to civilian life – some former serving members have difficulties adjusting to civilian life after leaving the ADF, caused by a wide range of factors including

unemployment, the impact on families, social isolation, the complexities of dealing with DVA and other service providers, and alcohol and drug abuse.

- Exposure to trauma – military service involves higher risk of exposure to trauma (i.e. physical injury and emotional distress) than in the general population.
- ADF Culture – some submissions to this Review highlighted aspects of the ADF culture, such as verbal abuse, time away from family, and frequent transfers and rotations across the country, which were perceived as contributing factors to self-harm and suicide.
- Moral injury and survivor guilt – some ADF members find it difficult to accept or come to terms with the consequences of actions taken or not taken during service, and can experience ‘survivor guilt’ (why them and not me), which may occur at any time during service and after returning to civilian life.

### The transition from the ADF

Between 5,000 and 6,000 service personnel leave the ADF each year. Of these, most go on to live healthy and productive lives, with only one in five transitioned personnel seeking assistance through DVA supports.

However, some serving members experience transition from the ADF as a significant adverse life event, which can increase their risk of suicide and self-harm. A wide range of specific aspects about the risks inherent in transition that may contribute to this experience have been raised with the Commission.

- Psychological transition from being a ‘warrior’ to becoming a civilian is an essential aspect of successful transition to civilian life. However, many report this is not addressed in ADF transition processes.
- Involuntary discharge (for medical reasons, for instance) can have adverse implications for the service member’s wellbeing.
- For most ADF personnel, transition includes relocation, primarily to the place they lived before joining the ADF or to the place where their partner lived or currently lives. This can have implications for ensuring continuity of care for those who leave for medical reasons.
- Transition also impacts on the family, especially when relocation is required or if the former serving member requires family members’ assistance in managing or delivering ongoing medical treatment and support.
- Some ADF members report they feel that the skills and training they acquired during service are not relevant to employment in the civilian workforce or not understood or valued by civilian employers, and that there is a perception that former service personnel are ‘damaged goods’.
- Some serving personnel leave without any clear plans for the next phase of their life, ‘feel lost’ after leaving the ADF and have no sense of purpose.
- The absence of ongoing contact with mates and colleagues still serving in the ADF can reinforce the sense of isolation and loss associated with transition.

- The Review also heard the perception that some serving personnel are so institutionalised or dependent on the ADF that they fear returning to civilian life and are unable to return to civilian life without support.
- It is also noted that information on career transition is not easily located on the ADF website where it is located under rehabilitation services

## Families of current and former ADF members

Families of current and former ADF members – their spouses and partners, children, parents and close friends – can play an important role in protecting serving and former members from suicide or self-harm. Information from the literature review and academic sources supports the proposition that families can be part of the fabric of protective factors that reduce the risk of suicide for members of the military, can assist in recognising signs that a member may be at risk, and can play a supportive role in assisting members in treatment and recovery.

This role must be understood, however, in the context of military family life, which presents unique experiences and challenges that differentiate military families from the broader population.

For instance, regular re-postings for serving members pose particular challenges for families. Reassignment to a different base is often to satisfy the ADF's requirements to have an operationally capable military force and extended periods of absence are a routine feature of military service. However, it is notable that this can cause considerable disruption to the lives of other family members, and the overall cost-benefit of regular postings must be questioned. The 2015 ADF Families Survey<sup>9</sup> highlighted this, finding that:

- 42% of respondents had moved between one and three times, and 11% had moved more than 10 times during their service career. More than half (56%) of all relocations had occurred within the past two years, and only 13% of respondents had relocated more than five years prior to the survey.
- Those issues which were reported as difficult or very difficult aspects of relocation included re-establishing spouse/partner employment (56%), personal support networks (53%), access to support services (52%), childcare (50%), and after school care (47%).
- Overall, 11% of respondents (ADF members and their families) currently reported living apart as Member with Dependents (Unaccompanied), and 25% of respondents advised they had lived apart within the last five years. Reasons cited included maintaining employment (55%), maintaining current support networks (25%) and not wanting to disrupt the education of their children (15%). The experience of living apart as Member with Dependents (Unaccompanied) was reported to have contributed to decisions to leave the ADF in the near future for 22% of Senior Officers and 38% of Senior Non-Commissioned Officers.

The feedback provided to the Commission throughout the course of the Review also highlighted:

- The routine of military life creates a set of unique stressors for families, including the anxiety and concern about the safety and wellbeing of the person who is in service,



particularly when they are away from home, and especially when they are away on deployment.

- Incidents of domestic violence, and drug and alcohol abuse, and the impact on the family of living with a service person who has a physical injury or a mental illness but cannot or will not access treatment services.
- The potential for negative mental health impacts for families as a consequence of their association with the military.

As is the case for families and carers of people with mental illness in the community, families of current and former serving ADF personnel often also require support themselves to be able to provide effective support for others.

## 1. The range of services available

In undertaking this Review, the Commission took a broad interpretation of the services involved in the prevention of suicide and self-harm, including mental health and wellbeing services, as well as other programs and supports that help to reduce the risk of suicide and self-harm.

The services provided by Defence and DVA to current and former serving members of the ADF, and their families, vary widely in nature, and are summarised below. Detailed lists of services provided through Defence and DVA are at Appendices E and F.

The Commission notes that the range of services available to current and former members of the ADF, and their families, has improved in recent years. This has particularly been in response to the independent Dunt reviews in 2009.

Feedback received through the Review indicated a broad acknowledgement of the range of services available – particularly to current-serving ADF members – but also many of the limitations of these services in practice. These limitations are considered in more detail later in this report.

### Services for current serving ADF members

The ADF is responsible for direct provision of a range of services for serving personnel. These services can be broadly characterised as:

- information services designed to raise awareness, and improve understanding and mental health literacy, including online information resources and e-health services
- suicide prevention training seminars and workshops for ADF members and ADF mental health professionals, delivered under the Suicide Prevention Program.
- protective services such as the BattleSMART resilience training program
- screening programs for deployed and non-deployed members, such as the Periodic Mental Health Screen, Post Operational Psychological Screen (POPS) and Return to Australia Psychological Screening (RtAPS) to identify 'at risk' service personnel
- clinical treatment services including on-base primary health care (diagnostic assessments, in patient non-specialist care) supplemented by off-base specialist care and hospital care
- the ADF Rehabilitation Program
- drug and alcohol management and treatment programs
- Defence transition support services (i.e. Transition Handbook, ADF Transition Centres, Transition Health Support)
- some online services provided by DVA (such as At Ease and High Res), promoted via the ADF Fighting Fit online portal.

In Defence, Joint Health Command (JHC) is responsible for the provision of the health care system, oversighted by the Surgeon General ADF/ Commander JHC. The mental health, psychology and rehabilitation services in Joint Health Command are increasingly provided in coordination with the Defence welfare support agencies, including the Defence Community Organisation and Defence Chaplaincy. Services available to current serving members are generally the same as – if not better than – those available in the general community through Medicare. Mental health and psychology services are provided as part of the Defence health system, with tiered responsibilities as follows:

- Garrison Health Operations branch provides the strategic planning, advice and governance over the regional health services provided at the Joint Health Units
- the ADF Centre for Mental Health provides a national operational level for workforce training and the management of clinical programs, for example, the Second Opinion Clinic
- Regional Mental Health Teams (RMHTs) are responsible for regional operational delivery, including clinical supervision of service providers and coordinating services for the Joint Health Units. These teams are generally structured as follows:
  - The RMHT Coordinator
  - Senior Mental Health Professionals
  - Mental Health Promotion Officer
  - ATODS (Alcohol, Tobacco and Other Drugs) Coordinator
- Mental Health and Psychology Sections operate at the tactical level, providing local health services to ADF members.
  - Mental Health and Psychology Sections provide both organisational psychology services (for example, job selection activities for internal transfers) and clinical mental health services, including intake, comprehensive and risk assessments, mental health treatment, and multidisciplinary case allocation and case review.
  - Services are provided through clinical resources internal to the ADF as well as through external clinical resources provided via contract, predominantly through Medibank Health Solutions, or an approved Defence provider, or through the Veterans and Veterans Families Counselling Service (VVCS).
  - MHPS services are provided by uniformed, Australian Public Service, or contracted Defence Mental Health Professionals. These may be Defence Medical Officers, Mental Health Nurses, Psychologists – including provisionally registered psychologists working under supervision – or Mental Health Social Workers.

For current serving members, there are various pathways for accessing services, including:

- On-base through Medical Officers at the base Health Centres and Clinics
- To the MHPS through:
  - Medical officers at the base Health Centres and Clinics
  - Chain-of-Command referrals
  - Self-referrals
  - Mental health screens
  - Chaplaincy
- Off-base services through:
  - Medical Officers
  - MHPS
  - Self-referral (e.g. to VVCS or via helplines)

It should also be noted that the range of health, mental health and suicide prevention services in the general community (such as private psychology or psychiatry, or services provided by community organisations or ESOs) are also available to current serving members who seek access to them, although in many cases this could require the person to seek access off-base. Going off-base is also required to access services provided by VVCS.

## Services for former-serving ADF members

The services for former-serving personnel funded through DVA include:

- post-discharge GP health assessments
- mental health treatments through:
  - GP, psychologist, psychiatrist, and social work services
  - pharmaceuticals
  - in-patient and out-patient hospital treatment
- services through 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)
- a range of health and wellbeing programs such as Stepping Out (transition program), Day Club, Men's Health Peer education, and Veterans Health Week.

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.

Former serving ADF members also 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 ESOs), and post-traumatic stress disorder (PTSD) treatments services in the community.

## Services for families

VVCS is a key provider of services for family members of both current and former serving ADF members. Services available include an after-hours telephone counselling services, case management, outreach counsellors for those who cannot access a VVCS centre in person, and online information and self-management tools.

Families are also eligible for many of the support and counselling services offered to current and former-serving ADF members, such as online resources, apps, and DVA case coordinators. However, families do not have access to the same level of health services that are available to current and former serving members, such as through non-liability health care arrangements.

Other services for families of current-serving ADF members include:

- Defence Families Australia – provides advocacy services and a helpline and is the official body appointed by the government to represent the views and needs of Defence families, to inform government and Defence, influence policy, and make recommendations on matters that directly affects Defence families.

- National ADF Family Health Program – helps to reimburse the gap expenses for medical services provided to the dependants of ADF members through Medicare.
- All Hours Support Line
- National Welfare Coordination Centre – a helpline that provides information and referral into Defence and community supports.
- Defence Community Organisation – offers a range of programs including the 24-hour Defence Family Helpline, information and resources, transition seminars, resilience programs (FamilySMART, KidSMART and TeenSMART), bereavement services and financial support for families who need to travel to visit their ADF family member should they be hospitalised during service.
- Defence Housing Australia – provides housing and related services for Defence members and their families.
- various ADF-run family engagement activities.

The Government is also trialling a pilot program for the children of current and former serving members of the ADF with mental illness. An evaluation of the program is expected in 2018-19.

### **DVA health cards and non-liability health care**

While not a service per se, many services are made accessible via DVA-issued Health Cards for veterans, war widows and eligible dependents.

These cards enable a streamlined process by which the card holder is automatically reimbursed by DVA for the cost of treatment received, removing the need to obtain and submit receipts or invoices for payment. Health card holders can choose whether to use their card or access the service as a civilian, using their own funds, private health insurance or Medicare rebates.

There are two main types of treatment cards – Gold Card and White Card. There are different eligibility requirements for each type of card.

A *Gold Card* entitles the holder to DVA funding for all clinically necessary health care services, and all health conditions, whether they are related to war service or not. Veterans or the widow/widower or dependant of a veteran, may be eligible for a Gold Card. In effect, the Gold Card is a substitute for private health insurance.

There are a number of criteria for eligibility for the Gold Card, including being the recipient of certain pensions, or being able to establish a level of disability or impairment above defined minimum thresholds for certain prescribed conditions. A person must continue to meet the relevant criteria in order to remain eligible for the Gold Card.

A *White Card* is available to former serving ADF members through two primary pathways:

- for the care and treatment of accepted injuries or conditions that are war caused or service related; and
- non-liability health care, where members with one or more day of service can get immediate help or treatment for five major mental health conditions (posttraumatic stress disorder, anxiety, depression and/or alcohol or substance use disorder), whether or not the condition is related to service.

For former-serving members accessing treatment under non-liability health care arrangements, a range of mental health treatments are available. These include treatment from a general practitioner, medical specialist, psychologist, social worker, occupational therapist, psychiatrist, hospital services, specialist PTSD programs or pharmaceuticals.

Non-liability health care claims can be determined immediately for people requiring emergency mental health treatment. Current and former serving members can apply in writing (including online or by email) or over the phone. A formal diagnosis of the mental health condition is not required up front, but must be provided within six months of approval in order for the treatment approval to become permanent.

Overall, the Review heard that the provision of services under the White Card for the range of mental health conditions specified has been well received but that many people were not aware of it. There would be benefit in wider promotion of the availability of this option.

## 2. The effectiveness of services

### Assessing effectiveness

In considering the effectiveness of services, the Commission takes a whole-of-life, person-centred approach, with a primary focus on the outcomes and experiences of individual people who access those services. In addition to clinical improvements, the Commission has previously identified a number of indicators for measuring outcomes of a contributing life<sup>10</sup>, such as a person's housing circumstances, level of social and economic participation, physical health status, experiences of stigma and discrimination, and experience of services.

The Commission notes that many of the programs and services delivered by the ADF and DVA have a sound evidence base, grounded in the literature about suicide and self-harm. The Commission also acknowledges that there have been some attempts by the ADF and DVA to evaluate some programs. However, this Review found insufficient information to empirically assess the effectiveness of services available to current and former serving members of the ADF, and their families, in relation to self-harm and suicide prevention.

- There are no direct measures of effectiveness (i.e. achievement of outcomes) for the services provided by the ADF and DVA. The only data that is available relates to outputs (e.g. the number of services provided, and the number of people attending training), which does not provide meaningful information about whether a service has achieved its intended outcome for its client (e.g. higher resilience) or client group (e.g. lower rates of mental illness or suicide attempts).
- The Commission notes that, while useful for the purposes of system-wide transparency, the rates of self-harm, suicide and suicide attempts are not appropriate metrics for assessing the effectiveness of individual services, given the complexity of these issues.
- A lack of evidence around effectiveness is not uncommon in relation to mental health and suicide prevention services more broadly, and an issue that is frequently commented on by mental health and suicide prevention reviews and inquiries.<sup>11</sup> However, this is an issue that has previously been recognised in a military context, for example, with the 'Review of Mental Health Care in the ADF and Transition through Discharge' commissioned by the Minister for Defence Science and Personnel and the Minister for Veterans' Affairs in 2008, explicitly recommending rigorous evaluation of all programs.

### *Perceptions and experiences of service effectiveness*

The Review considered additional material in relation to the question of service effectiveness, including qualitative information from interviews with key informants and group discussions. The Review also undertook a survey to gather information about the how service effectiveness is perceived by current and former members of the ADF, their families, as well as by service providers themselves.

While the Commission notes that subjective reflections on the experience of services is not a comprehensive measure of effectiveness, per se, in the absence of more robust measures it can provide valuable insights into how services are operating in practice from a user-perspective, and is a method that is starting to be used more broadly in population-wide mental health services (see, for example, the Your Experience of Services survey<sup>12</sup>).

These additional sources of information identified some areas of promise in terms of the experience and perceptions of service effectiveness.

- Current and former ADF members who had received treatment for mental health issues generally rated services very positively (further information and analysis is available in the supporting paper provided as part of this Review on Survey Preliminary Results, particularly Tables 27, 28 and 29, and Figures 1 and 2).
  - Of current and former ADF member survey respondents who had received treatment for a mental illness and/or suicidal and self-harm behaviour in the last 12 months, more than half (54-68%) felt they had adequate access to services ('always' or 'nearly always') – this is higher than community surveys of the general population.
  - The vast majority (77-90%) of people who had received treatment rated their treatment as 'fair', 'good', 'very good' or 'excellent'.
  - However, room for improvement was also flagged, with 9-20% rating their treatment as 'poor' or 'very poor', and around one fifth (14-22%) feeling they were only 'sometimes', 'not often' or 'never' treated with respect and dignity by the service provider.
  - Current serving members reported they felt listened to, felt trust and confidence in their health professional, were treated with respect and dignity, and were given enough time to discuss their condition in more than 65% of cases; this was reported less frequently in relation to ADF GPs.
  - For former members, across all services, those who had used their DVA card, rated their experience of services higher than those not using their DVA card. GP's and Psychiatrists were generally given similar ratings, though GP's accessed without using a DVA card were consistently rated lower than other services.
- The VVCS was frequently cited and praised for the services it provides.
  - VVCS counselling services was one of the highest rated services in the survey conducted for the Review, with medium to high ratings of service effectiveness from around 70% of current serving members and 57% of former serving member survey respondents. However, more than 50% of family members rated VVCS services as of low or very low effectiveness.
  - Qualitative feedback to the Review indicates that the confidential nature of VVCS (and other private or community treatment services) is particularly valued by currently serving members of the ADF who can usually access the service and receive assistance without the knowledge of their commanding officers or other members of their team. This can reduce the stigma of disclosing a mental illness and the perceived loss of face (weakness) that comes with other, more public forms of help-seeking, and avoids the perceived risk of jeopardising future deployment and employment opportunities.



- However, the Commission acknowledges there are some trade-offs in anonymous access to service (discussed in more detail below, under Barriers to accessing services).
- The DVA Gold Card was also rated relatively highly by former serving members and their families (72% and 54%, respectively), as well as by service providers.
- The Review also heard positive comments about the care provided by mental health nurses, chaplains and padres, psychologists and psychiatrists (once gaining access – discussed further below), and other services internal to the ADF.

For other services presented in the survey, preliminary results suggest that former serving members and their families generally had poor perceptions around service effectiveness, particularly mental health and/or suicide prevention support programs, PTSD treatment services and support for families.

Service providers who responded to the survey also rated many services poorly, including the National Welfare Coordination Centre, mental health and/or suicide prevention support programs available through Medicare in the community, ADF drug use prevention and treatment services, defence families' services, post discharge GP health assessments, and PTSD treatment services.

The findings reported here draws on preliminary analysis of the survey data. The Commission notes that further, more detailed analysis may be required in order to more comprehensively understand these results.

### Issues identified relating to perceptions of service effectiveness

Some common features of services perceived to be effective that were raised throughout the Review include:

- service providers with a good understanding of the military experience, including providers within the ADF, some ESOs and delivery by peers who are also serving or former-serving members
- services that are matched to need (rather than, for example, rapid escalation to acute settings for relatively minor mental health concerns; discussed further below in relation to Stepped Care)
- multi-disciplinary services
- services that are evidence-based.

The Commission also heard some conflicting messages regarding effectiveness:

- services available anonymously are seen as effective, as are (conversely) those that are readily available such as on-base or via Chain of Command referrals
- services that involve families are seen as effective, as are (conversely) services that do not.

Such differences of opinion illustrate that service responses are not 'one size fits all' and need to be tailored to the individual's needs and circumstances, including their particular position or role in the ADF.

Information presented to the Review offered a range of explanations for the finding of low perceived service effectiveness. For example, the Commission received advice from individuals that:

- some service providers are perceived to have no/limited understanding of military culture and military service, which can be exacerbated by turnover amongst health service providers. This lack of understanding can have adverse consequences for the quality of treatment and the willingness of current and former serving members to seek help and assistance.
- some commanding officers appear to perpetuate the stigma associated with mental illness despite the efforts of the ADF to do otherwise. Illustrating that there is some variation in this regard, the Commission also heard comments that commanding officers can be very supportive and the most appropriate person to coordinate support. Stigma is considered further under 'Barriers to accessing services', below.

Other matters relating to effectiveness identified through the course of the Review include issues around: recruitment, transition, support for families, Gold Card arrangements, quality of outsourced services, and DVA administrative processes. These are considered in more detail below.

### *Recruitment*

Consistently throughout the Review, the Commission heard of a strong belief that ADF recruitment processes are leading to inappropriate outcomes for recruits and members. This Review did not examine information about recruitment in detail, such as recruitment processes, screening tools and recruitment outcomes. However, this is an area that the Review has identified as particularly contentious.

For example, we heard accounts of:

- people being recruited into the ADF despite failing screening tests, in order to meet recruitment targets
- those administering the screening assessments not having the appropriate qualifications, skills or expertise, or understanding of what the ADF requires of its personnel
- the ADF overruling recruitment screening outcomes in order to meet operational requirements for 'boots on the ground'
- new ADF members being assigned to unsuitable roles
- screening processes being unable to detect whether people are withholding relevant information (such as a history of mental health difficulties)
- a lack of involvement of families in the recruitment process.

The Commission understands that in some cases, recruitment and recruiting assessments that prevent entry for a candidate on the basis of a prior mental health problem can be waived in order to allow the person to be recruited. Of 81 such waivers granted since 2012-13, only three members have since been medically discharged, of whom only one was for a mental health related condition.<sup>13</sup> This suggests that the approach taken to managing psychological risks in recruits is a considered one. However, little is known about the occurrence of mental health problems, self-harm, suicide or suicide attempts amongst such members following their discharge from the ADF. The Commission also understands that recruitment documentation is rarely considered in the review of an event of suicide, self-harm or presentation with mental health problems post-service.

The Commission was advised by the ADF that its recruitment processes are comprehensive and robust. Given the strength of contrary views heard throughout this Review, at minimum, it appears there is a problem of perception and communication by the ADF, with a large

disconnect between recruitment and quality assurance processes in practice, and how these are perceived on the ground.

The Commission also notes that many ADF members are recruited at an age when identity formation, attachment and development of independence is critical, and that their early career experiences can be formative. Recruitment is also often in an age bracket in which mental health problems emerge for the first time. These innate characteristics should be taken into account when considering the impact of ADF service and the supports needed for ADF members who are recruited and leave the service at a relatively young age.

#### *Routine organisational matters*

Throughout the Review, the Commission was made aware of concerns around the effectiveness of a number of activities that are undertaken within the ADF on a routine or regular basis. These concerns included that:

- the screenings and assessments within the ADF (e.g. the POPS and RtAPS following deployments and other operations) may not always detect when a person may be experiencing problems. As these tools are used on multiple occasions, the Commission heard it is possible for ADF members to 'learn' how to respond to avoid detection.
- screenings and assessments largely use a form-based 'tick a box' approach rather than more flexible discussions that allow for detailed information about an individual's particular circumstance and that sometimes they aren't done at all, or they are conducted in group forums which discourage disclosure.
- there is a perceived conflict of interest in some cases where a mental health professional both provides treatment and administers and makes recommendations on the results of mental health screens.
- some mental health and suicide prevention training and awareness programs are of poor quality, such as unimaginative workshops or powerpoint presentations, which undermine both the purpose of the training and foster a cynical response that the ADF (like the presenters) is just going through the motions and isn't serious about tackling the issue of preventing suicide.

#### *Transition support*

The issue of transition – and the risks it raises for some members – was raised with the Commission in every forum, in every element of the research commissioned for this Review (especially the group discussions and key informant interviews) by the most recent recruits and some senior and experienced ADF commanders.

The information presented to the Commission suggests the current transition process are experienced as routine administrative "tick and flick" exercises that suit the purposes of the ADF, but are not always in the best interests of the individual serving member, or their families. One reflection on this process heard by the Commission was "they paid a million dollars to train me, and 20 cents to discharge me".

The Commission notes a recent report<sup>14</sup> published by the Australian National Audit Office says there are problems regarding consistency, coordination, and the duplication of transition rehabilitation services for those leaving the ADF with a medical discharge, and that

*'the transition experience for injured and ill ADF personnel remains lengthy, complex and inconsistent'*<sup>15</sup>.

The ANAO report also identified that DVA *'cannot yet demonstrate through comprehensive and reliable performance information whether the [rehabilitation] support provided is effective and efficient in assisting transition to civilian life or which services provide the best results for injured and ill ADF personnel discharged for medical reasons'*<sup>16</sup>.

A number of submissions suggested the goal of transition should be to successfully integrate ex-service personnel into the civilian community, and that successful transition processes require a plan and a number of interactions with the ex-service member after discharge, including annual reviews. These submissions suggested continuity of service delivery during the transition period is important and that the ADF needs to ensure ongoing case management and engagement through civilian service providers.

### *Support for families*

The findings of this Review's survey suggest a high level of dissatisfaction with services provided by the ADF and DVA for families. Some explanations for these results are offered by recent surveys of defence families undertaken by Defence.

For instance, the 2015 ADF Families Survey<sup>17</sup> noted:

- feedback from respondents that the available support services offered by Defence are limited in that they typically catered only for traditional nuclear families'.
- a decline in the numbers of family members who were aware of pre-deployment briefings or who valued the information provided at the briefings.
- only just over a third (36%) of people attending DCO education sessions reported the sessions were useful.
- a decline in the proportion of people contacted through a DCO support call (i.e. calls made by DCO to partners whilst their partner is deployed) who found the call useful (from 39% in 2012 to 26% in 2015); nearly half (49% in 2015) of respondents indicated they had not been contacted at all.
- more than two-thirds of respondents felt uninformed about the role of the National Welfare Coordination Centre, and half were uninformed about the role of the DCO.

A 2014-15 study by the Australian Institute of Family Studies (AIFS), commissioned by Defence Joint Health Command (JHC) considered the role of defence families in the rehabilitation of ADF members. The strongest theme reported in this study was *"the need for better integration of services and a need for a renewed emphasis on effective communication between all involved in rehabilitation services to better support both members and their families"*<sup>18</sup>.

The experiences of all those involved in the AIFS study revealed that family engagement was uncommon and not seen as a priority for, nor proactively pursued by, the ADF. The AIFS study also identified some ambivalence toward the role of the family in the rehabilitation journey among service providers. The AIFS report also highlighted the 'struggle in silence' many families experience particularly in relation to mental illness of their ADF family member.

Noting the important role of families in supporting recovery and rehabilitation of current and former serving ADF members, the findings of this Review suggests more work around engagement with families is needed.

### *Non-liability health care and the Gold and White Cards*

The Commission was presented with considerable material regarding the Gold and White Cards and non-liability health care. The principle of 'no liability' access to services was roundly supported. The Commission understands that the ease of access to mental health services and the timeliness of application processes have been improved, but that many people are not yet aware of the availability of mental health services through non-liability health care and the White Card. The issue of awareness of services is considered in further detail below under 'Barriers to accessing services'.

Although the Gold Card was rated relatively highly by survey respondents, the Commission also heard that the eligibility requirements for the Gold Card can give rise to perverse incentives for former personnel to stay unwell in order to maintain access to its benefits. A person eligible for the Gold Card on the basis of total and permanent incapacity, due to a mental health condition for instance, can lose eligibility if their condition improves or other circumstances change. The possibility of losing eligibility can therefore discourage people from seeking early intervention for mental health concerns and – in some cases – lead to higher use of expensive or unnecessary treatments.

As with other service arrangements in the broader health and disability systems, establishing total and permanent incapacity on the basis of a mental health condition can be complicated.

- A person with a mental illness – even if severe and persistent – may have periods of wellness. However, periodically and sometimes regularly, the same person can experience severe symptoms that limit their day to day functioning. This episodic nature of mental illness can disrupt connections to employment, family and community and can make service continuity difficult to plan and achieve.
- For people who experience severe episodic symptoms, it is critical that they are able to access both preventative and treatment services in a timely way, in order to appropriately manage their condition and prevent their symptoms from escalating to an acute phase (such as a suicide attempt).
- At the same time, it can be challenging to accurately assess eligibility for high-value arrangements that enable access to comprehensive services (e.g. a similar challenge has been experienced through the National Disability Insurance Scheme) and that may offer other benefits such as income support and exemptions from activity testing (e.g. as is the case for the Disability Support Pension).

The Commission acknowledges this is a highly complicated and contested issue, and suggests this is an area where further consideration may be required.

### *DVA administrative processes*

The Review repeatedly heard feedback around difficulties in dealing with DVA on administrative matters. The issues raised include individuals' lack of understanding of the processes and procedures (how to submit claims, what documentation is required, etc.), the length of time to process applications, the complexity of the processes, the frustration of lost paperwork and the need to constantly prove claims.

The consequences of these difficulties include:

- significant aggravation and distress, and potentially a worsening in severity of a veteran's condition
- reinforcing behavioural expectations in former members that they must remain 'unwell' to avoid losing any compensation or other benefits to which they may be eligible
- reinforcing in the former member a form a personal identity that they are 'broken' and unwell, and that this is how they will be for the rest of their lives
- distrust of DVA and widespread anger and perceptions that former service members have been betrayed by the government and an ungrateful Australian community.

The Commission notes that options for improving administrative processes are currently being considered by DVA. One potential approach suggested throughout the course of the Review is to introduce processes for the automatic submission of a claim to DVA at the same time that an injury is reported to Defence. As well as streamlining the administrative process for the member, this would also help to establish liability early, while the member is still serving, and help to avoid time and effort through later investigations.

### 3. Duplication or gaps in current services

The Review heard little specific evidence about duplication in current services. On the other hand, there is ample material to suggest there are a number of gaps in services that are worthy of closer consideration.

In considering gaps and duplication, the Commission was guided by two key frameworks: stepped care and trauma-informed practice.

#### *Stepped care*

To identify gaps in services for current and former ADF members and their families, the Commission was guided by the stepped care framework. That is, designing a service system that provides a range of help options of varying intensity and that matches services to people's levels of need, including through clinical staging, based on robust clinical and functional assessments.

A stepped care approach aims to ensure the right services are available for the right people, when and where those services are needed. This means services are available across the range of acuity of mental health problems, from prevention and early intervention initiatives (including evidence-based self-help tools), accessible clinical and non-clinical services to support people with mild to moderate mental health problems, through to acute responses to emergency events or severe mental illness. It also takes into account non-clinical services that may be required to support a person to live a 'contributing life', such as links between services for primary health, mental health, housing and employment. Importantly, a stepped care approach allows an individual to 'step-up' or 'step-down' to different intensities of service, depending on their needs at the time.

While stepped care approaches are increasingly being recognised and adapted in the general community, the task of implementation can be challenging. The Commission acknowledges that achieving a holistic stepped care approach to mental health and suicide prevention within the military context similarly may require organisational and philosophical realignment within and across providers and systems. Given both Defence and DVA rely, to a greater or lesser extent, on services and systems in the community, considerations around their own services and systems should take into account the maturity of stepped care arrangements for mental health and suicide prevention in the broader health system.

#### *Trauma-informed practice*

Another critical framework that the Review heard is missing in the range of services provided by the ADF and DVA is that of trauma-informed care. This approach recognises the impact of trauma on a person's development, behaviour and coping capacity, sensitively seeks information about traumatic experiences, and responds appropriately to the disclosure of trauma (such as by validating the experience and reassurance). Trauma-informed care should be individualised and tailored to the person's unique circumstances, and should ensure that treatments and services do not create additional trauma for the person, or reactivate their past traumatic experiences.<sup>19</sup>

Australia's mental health systems more broadly are only recently recognising the relationship between trauma and the development of mental health conditions, with a need for more awareness and education about trauma-informed approaches within practice and service settings.

Trauma-informed care is clearly important in a defence context. Prevention opportunities exist at all levels of illness severity and at all points throughout and following service in the ADF. The Review heard feedback that there are gaps in understanding by the ADF and its personnel regarding trauma-informed care, how this approach could be implemented across the entire course of service, from training, through to deployment, upon return from deployment, and upon exiting the ADF.

### Gaps in a stepped care framework

Feedback provided to the Review suggested there is a need for a stronger stepped care focus, particularly for services delivered within the ADF for current serving members. While there appears to be a range of service offerings and processes in place, the Commission heard that people's experiences of service responses to mental health concerns (including suicide and suicidal ideation) amongst ADF members is often a rapid escalation to off-base hospitalisation. There are a number of concerns regarding this approach:

- it is a response that in the community is generally reserved for acute situations and that does not align with the best practice principle of least restrictive care
- it is an expensive option and is often unnecessary to support a person's recovery
- it means inpatient beds are sometimes used off-base for members with mental health concerns, even if this is only for short-stay observation or until appropriate alternate arrangements can be made, when other less acute settings may be possible or more appropriate
- the off-base delivery of treatment may contribute to stigma around mental health concerns and decreases the likelihood of people seeking help early when they need it.

The Commission suggests there are less acute service options that could be considered in the ADF context as alternatives to hospitalisation or other off-base services. Options include in-patient services that are provided on-base, telepsychiatry and building internal specialist clinical capacity with services provided on-base within the ADF.

It was suggested to the Review that additional 'step-down' services and supports could be considered, particularly meaningful employment options for ADF members who are considered not fit for regular duty and/or deployment but nevertheless able to work on other duties.

Gaps in stepped approaches are also apparent in the gaps identified in relation to integration with non-clinical services, particularly employment and other transition services for former serving ADF members (discussed further, below).

Consistent with a 'veteran centric' approach to stepped care, services and systems should also recognise and support the role of family in the care options for current and former serving members of the ADF, including supports for family members themselves where needed.

Effective stepped care arrangements also need to consider how to leverage integration across all service sectors, which in the military (i.e. ADF and DVA) context includes services provided by ESOs and others in the private and community sectors.

### *Prevention and early intervention*

Early intervention is a key component of a stepped care approach, but an area in which there appears to be critical gaps in the current service offering for current and former



serving ADF members and their families. One stakeholder to the Review referred to the need for “brain training, that goes along with weapons training and physical conditioning soldiers do routinely”.

Opportunities for improvement in this area include:

- the provision of transition services across the life course of military service to better prepare ADF members for civilian life.
  - A number of submissions to the Commission made the point that the ADF recognises the need to devote considerable time, effort and resources to train civilians to become ‘warriors’, but provides comparatively little to assist in the process of re-adjustment when a member’s military career ends.
- low-intensity supports within units (such as full-time peer-based welfare officers)
- integration of peer workers into existing services
- introduction and promotion of effective digital and online services, including in for the provision of low-intensity treatments
- more accessible and user-friendly avenues for information about suicide, self-help, mental health and wellbeing
- more widespread life skills and resilience training
- better coordination by both ADF and DVA with ESOs in the delivery of community and welfare services.

#### *Gaps in multidisciplinary care teams*

The various intensities of services offered in a stepped-care system need to be supported by a workforce that is similarly varied in terms of experience and expertise.

Within the ADF, information was presented to the Commission around shortages of some mental health professionals in Regional Mental Health Teams and within the ADF’s Mental Health Psychology Service, as well as a lack of internal specialist capabilities such as uniformed psychiatrists and mental health nurses. The Review also heard that vacancies in mental health teams can be exacerbated from time to time by freezes in recruitment in the Australian Public Service, and that there are apparent difficulties of the ADF in recruiting and retaining trained health care professionals.

The Commission also notes that a lack of positions similar to mental health peer workers could also be considered a gap. Peer workers are particularly important throughout all levels of stepped care. For example, they can be effective as first points of call for people experiencing low levels of mental health concerns, and – working as part of multidisciplinary teams – can also help to improve effectiveness and efficiency in the delivery of more acute services. While the role of unit welfare officers within the ADF is to be commended, the Commission heard this could be improved by these being full-time roles. Some gaps in the service landscape both within the ADF and in DVA services could be effectively addressed through better utilisation of current and former serving ADF personnel who have a lived experience of mental illness and/or suicide.

## Ex-Service Organisations (ESOs)

The role of ex-service organisations (ESOs) was frequently raised with the Commission throughout the Review.

There are more than 3,000 non-government organisations in Australia that exist for the sole purpose, or the primary purpose, of providing services to and on behalf of former service personnel. Some ESOs are long-standing organisations with a national footprint, like the Returned Services League (RSL), whereas others are much smaller, with a small number of members, very specific purposes, and small geographic footprints within a single state or locality. There is limited information about what support services ESOs offer.<sup>20</sup>

There has been a rapid growth in the number of ESOs in the last two decades in response to real or perceived gaps in services. A particular driver of this growth appears to be the view that the traditional ESOs are more focussed on an older generation of veterans (who served in the world wars through to the Vietnam War) and do not understand or cater for the needs of a younger generation of former service personnel.

The feedback received by the Commission presented mixed views on ESOs as providers of services to reduce the incidence of suicide and self-harm to former service personnel.

On the one hand, ESOs appear to have a number of inherent strengths that favour their ongoing role as service providers. For instance, information was provided to the Review that:

- Former serving ADF members appear to be more receptive to services that are provided peer-to-peer.
- Collectively, ESOs have an extensive geographic footprint, and the services are more likely to be found in close proximity to places where former service personnel live.
- ESOs are able to attract a significant amount of extra (i.e. non-government) resources for the benefit of former service personnel, including the time and effort of volunteers, and financial resources.
- ESOs are advocates for former service personnel, which generates goodwill in the community towards former service personnel, and their families.
- ESOs are more agile, innovative and responsive to the needs of former service personnel compared to DVA.

However, feedback also raised some concerns.

- In some cases, there are hostile and adversarial relationships between ESOs and DVA and other government service providers, potentially limiting opportunity for cooperation and leading to results that are not necessarily in the interests of former service members.
- The interventions of some ESOs on behalf of former serving members, though well meaning, may actually be counter-productive or indeed harmful to their welfare, for example where that behaviour may encourage a focus on loss, and a mindset and narrative about 'disability' to prove entitlement to a Gold Card, rather than a more positive and constructive approach focussed on wellness and ability.
- Some interventions may not be evidence-based.
- Anecdotal evidence suggested duplication in the services provided by ESOs.

The Commission notes that other concerns raised are not unique to ESOs, but rather can be common experiences for non-government organisations. These issues include:

- weak corporate governance, management and accountability structures
- rivalry between organisations to differentiate themselves from one another as they compete for funds (from the government and the wider community), attention and market share
- a lack of evidence around the effectiveness of services provided
- misalignment with, and disconnection from, strategic priorities being pursued nationally and/or state-wide.

The proliferation of ESOs has a number of possible implications for service users. For instance, more service offerings increase choice but also the chance of duplication and confusion for service users. Individual ESOs may be limited in the number of clients they can support and the scope of their services, meaning users may need to go to multiple providers to meet their service needs.

The observations and perceptions noted above do not necessarily reflect negatively on the capacity or appropriateness of ESOs in delivering services for current and former serving members and their families. Rather, it suggests a potential role for government to more closely engage with ESOs to harness their expertise, commitment and service footprint as part of a broader veteran-centric service strategy. Given the diversity of views and relative lack of information available to assess anecdotal feedback about the role of ESOs, the Commission suggests further investigation may be worthwhile to assess the services provided by ESOs and options for improved insights into, and coordination of, the delivery of services.

In this regard, the Commission notes the recommendation of the ASPEN Foundation's *Ex-Service Organisations Mapping* report for a self-regulatory system with accreditation, codes of conduct and a monitored minimum level of service delivery.<sup>21</sup> This recommendation has been supported by the Minister for Defence.<sup>22</sup>

## 4. Barriers to accessing services

### *Uptake of services*

In considering barriers to access, it can be useful to consider the rates at which services are being accessed.

For current serving ADF members, data provided to the Review indicated that between March 2015 and September 2016:

- around 23,500 cases were referred to the ADF's Mental Health and Psychology Services.
- Around 16,400 cases were referred internally to the ADF, 1,712 were referred to VVCS and 2,653 were referred to external services.
- referrals to VVCS were approximately twice as likely to be self-referred than internally from Defence.

For former-serving ADF members, Table 1 below shows the number of services, clients and providers involved in services provided via DVA health care cards in 2015-16, as well as the overall funding for these services from DVA.

**Table 1: Veteran Mental Health Services, 2015-16**

	Services	Cost(\$m)	Clients	Providers
Occupational Therapy	1397	\$0.13	192	34
Psychiatry	118,288	\$23.0	17,897	1,257
Psychology	45,815	\$5.80	4,946	2,014
Social Work	8,278	\$0.90	967	110
<b>Total</b>	<b>173,778</b>	<b>\$29.96</b>	<b>21,571</b>	<b>3,415</b>

Many other services provided by DVA for former ADF members, and their families, are online or digital self-help tools. Some indicative figures on uptake of these services include the following:

- The At Ease website had around 26,000 users and 50,700 website page views over the six months from March to August 2016.
- HighRes – a self-help smart phone app to help manage stress and build resilience – was downloaded 7,200 times from January to August 2016
- The Operation *Life* app – which offers supports for people dealing with suicidal thoughts (and is recommended to be used with the support of a clinician) – was downloaded 900 times in the year to August 2016; in the seven months to August 2016, the website recorded around 2,600 sessions and 2,250 users.
- The PTSD Coach self-help app was downloaded 22,600 times from February 2013 to August 2016.

VVCS data provided to the Review suggests that service use has increased over the past seven years. In 2015-16, VVCS delivered counselling to 15,154 clients and group programs to 1,182 people, fielded around 6,300 calls to the after-hours veterans help line and supported around 300 clients through case management. These figures include both current and former serving members and their families.

DVA only becomes officially aware of a death by suicide of a veteran if a claim for compensation is lodged by a dependant in respect of the death of a veteran. Analysis of DVA data for claims submitted by a dependant of an ex-serving member from 2000 to 2016 indicates that, as at 30 September 2016, DVA had received 173 claims in relation to a death by suicide, of which 119 were determined to be deaths by suicide related to ADF service. Of the 173 claims, at time of death:

- 99 people had a DVA-issued treatment card (i.e. a Gold or White Card) and 35 were accessing treatment in the 12 months prior to their death.
- the bulk of treatment received was consultant psychiatry sessions, with people accessing between 1 and 33 sessions in the past 12 months (average of 9.6 sessions).
- three people had accessed psychology/clinical counselling, three had been prescribed medications, and there had been 12 admissions to public and/or private hospitals.

In the general community in 2014-15, people accessed mental health services through the Medicare Benefits Scheme at a rate of 87.6 per 1,000 population, with sessions delivered at a rate of 416.6 per 1,000 population.<sup>23</sup> Public community mental health services were accessed at a rate of 16.9 per 1,000 population, and 366.8 service contacts per 1,000 population.<sup>24</sup>

Gaps in the data mean that the rate of service access by current or former serving ADF members or their families cannot be compared with those in the general population. These data gaps include not knowing the proportions of services in the community that are accessed by current or former serving ADF members or their families and the total number of former serving ADF members and ADF family members.

Further information about the utilisation of services funded by the ADF and DVA is available at Appendix 1 of the 'Review of ADF and DVA documentation' report provided as part of this Review.

The key themes regarding gaps to accessing services arising throughout the Review are discussed below.

### **ADF culture and career consequences of seeking help**

Elements of the ADF culture itself may give rise to an environment and expectations (of oneself and of other members) which inherently present barriers to seeking help for mental health problems, self-harm and suicide. For instance, some people told the Commission that:

- The high value placed on strength and the ability to cope with adversity, can also lead to an intolerance of weakness, especially any form of mental weakness.
- The ethos of team-work within the ADF can also discourage help-seeking because 'you don't want to let your mates down'.

A strong theme heard by the Commission was that among the most significant barriers to help seeking among current serving members are concerns about the harm to career and career prospects, and that seeking help would prevent deployment and jeopardise employment in the ADF. The Commission heard that as a result of these concerns, some ADF members withhold information about their health and wellbeing from their unit and command, medical practitioners and screening processes. The concern around impacts on careers was similarly identified in the ADF Mental Health Prevalence and Wellbeing Study in 2010, and indicates this is an issue requiring attention.

It should be noted that the Commission is also aware there are some signs of change and efforts being made by the ADF leadership to encourage help-seeking by current ADF members. However, it appears these efforts are not consistently being applied across the ADF leadership or penetrating through to the culture, attitudes and practices on the ground. There needs to be continuing and consistent leadership at all levels to ensure full penetration of the critical message in support of help seeking when it is needed.

## Stigma

Information collected by the Review shows stigma is a significant reason that discourages help-seeking by both former and current-serving members, as it is in the general community.

The stigma associated with mental illness can stem from the individual themselves. This is referred to in the literature as self-stigma and is a frequently cited reason for not seeking help for a mental health problem. The Review's survey revealed that both former and current-serving members do not seek help because of concerns about:

- other people's perceptions (*people would see me differently*)
- a loss of self-respect (*I would feel worse about myself if I could not solve my own problems*)
- embarrassment (*I would feel embarrassed if I had a mental health problem*)
- loss of control (*most of what would happen if I sought treatment for a mental health issue would be beyond my control*).

The survey did not specifically seek information about people's attitudes towards other current or former serving ADF members with mental health concerns. However, anecdotally, the Review heard views that ADF members who return to the force following a leave of absence for treatment for a mental health concern or suicide attempt are looked down upon and not trusted. The Commission also heard that people are often referred to as being in 'platoon 11' – a label that represents a culture of stigma and low expectations of returning members' abilities to manage and overcome their difficulties and make meaningful contributions to their units.

As in the community more broadly, it appears that further work is needed to reinforce that people with experience of mental illness or suicidal behaviour can recover to lead productive, contributing and rewarding lives. The survey results suggest this is particularly the case for former serving members, for whom feelings of embarrassment, loss of self-respect and a belief that others wouldn't understand were rated as important factors in not seeking help.

It may be useful to shed light on the culture and attitudes of personnel within the ADF around help-seeking and experiences of mental illness, suicide and self-harm, and whether these attitudes differ from those in the general population. The Commission suggests this could be a fruitful area for targeted research in the future.

## Attitudes regarding access to off-base services

An issue that was raised through the course of the Review was the appropriateness of current serving members 'going off-base' to non-ADF providers to access services. From one perspective, doing so poses a potential risk as the chain of command, and the ADF Health Care system are unaware of problems being experienced by their personnel and is therefore unable to make assessments as to a person's suitability for deployment or other tasks associated with service. In contrast, seeking effective help when it is needed can help to reduce the likelihood that a person's problems will escalate to a point where they pose a

level of risk that would be of sufficient concern to the chain of command. Given the cultural and other barriers in the ADF to accessing services, the risks of not seeking help at all would appear to be much greater.

This is a complex area, involving, on the one hand, the right of an individual to choose the information they disclose and the services they access and, on the other, the responsibility of serving members to provide information that may be of operational importance or otherwise have a bearing on the safety and wellbeing of their colleagues and the ADF more broadly.

The Commission acknowledges that the balance between these contrasting arguments ultimately requires consideration by those with appropriate operational judgment and experience. However, the Commission would encourage the ADF to give consideration to the benefits of encouraging current serving members to take early action and seek help for emerging problems as they arise through whatever means available, including outside the ADF system or off-base.

### **Lack of awareness of services available**

A lack of awareness about the range of services available was a common theme in submissions, the survey (particularly for former ADF members) and to a lesser extent in the group discussions and key informant interviews.

The problem of awareness appears to have two dimensions: for serving members of the ADF, the range of services actually available will vary from base to base, and service to service, meaning members need to re-familiarise themselves with different service offerings with each posting; for former serving members, awareness will vary according to location, depending on a number of factors such as service integration, community engagement and presence of organisation and other sources of information.

The lack of awareness about services is a particular issue for former members (and their families) at two different times: immediately post-transition from the ADF, when the person is likely to move away from the base, often interstate, which has particular implications for continuity of care if they require ongoing medical treatment when they are discharged; and when problems subsequently arise, sometimes long after separation from the ADF, by which stage their family, friends and peers may be unable to understand the circumstances or offer much support. In both cases, the lack of awareness may be contributed to by general difficulties in navigating systems (in the ADF, DVA and the broader health system) that can be complex and opaque.

A number of submissions referred to the apparent lack of awareness of the White Card and non-liability health care arrangements. This is somewhat surprising, given the benefits through access to services that it carries, but may also reflect the relatively recent expansion of, and other amendments to, non-liability health care through the White Card to a broader range of mental health conditions.

### **Cost of services**

The cost of accessing health care can be an important barrier to accessing services. Some former serving members reported experiencing difficulty locating medical service providers who will accept the scheduled DVA fee, particularly where the veteran is seeking psychiatric, neurological and orthopaedic services. The Commission notes that this difficulty may be more commonly associated with finding a specialist to conduct assessments for

compensation claims, rather than for the purposes of receiving treatment, and may be an area where further investigation is required.

The cost of services is why access to the Gold and White cards is so prized. However, the effort required to prove eligibility for Gold and White cards is also a barrier, and in some circumstances, can exacerbate the conditions for which treatment is required, such as anxiety, depression and other mood disorders.

As noted above under 'Effectiveness', in some circumstances, the requirement to show illness or disability in order to obtain and maintain the Gold Card creates perverse incentives not to get well. This can present a barrier to seeking help, which might otherwise reduce a person's degree of disability or impairment and thereby jeopardise the opportunity to obtain a Gold Card. During this review, the Commission has often heard the comment that "the Gold Card is the gold standard".

### **High demand and waiting times**

For those who seek access to services in the community, members and former members (and their families) are competing with high levels of demand in the general population. Given the existing limitations of the broader system to meet these demands, access for current and former serving ADF members can be similarly restricted. This is particularly the case in relation to specialist services, which are very limited in many parts of the country, and for former members for whom access to specialist services is solely through providers in the community. The Review also heard of significant waiting periods for providers who will accept the DVA scheduled fee, given the high level of demand from other ex-service members.

### **Geographic location and distribution of services**

The Review heard that some former service members needed to travel significant distances to have their medical needs met. This was particularly the case for those who sought services inside the fee schedule, with costs being a particular concern for those with mobility, mental health and support barriers.

Proximity to services is a protective factor encouraging their use; conversely, extended travel times and distance are barriers to accessing services. While the Commission notes that assistance is available through DVA to cover the costs of travel for treatment, the issue of distance and the logistics required to arrange travel can nevertheless present barriers to services, particularly for people experiencing mental health concerns. Previous work by the Commission and others shows that mental health services more broadly are not evenly distributed across Australia.<sup>25</sup> While this is a broader issue for the health system more generally, it is one which the ADF and DVA need to be aware of in designing and commissioning their service systems.

### **Barriers for families in providing support**

The information presented to the Commission shows a complex range of issues and considerations that appear to be inhibiting families of both current and former serving members from playing a more active and constructive role. The key issues raised in submissions and other feedback presented to the Commission include:

- the poor quality of engagement with and information presented to family members, especially about the realities of service life and the range of issues and challenges faced by service personnel.



- privacy concerns expressed by members themselves, who may, for example, be concerned about the stigma of mental illness and wish to keep this a ‘secret’ from the family; who simply do not want family members to know about their health issues because “it’s not their business”; or who may simply not want family members to be concerned or worried.
- a more general view that privacy legislation is an impediment preventing the disclosure of personal medical information to family members.

In relation to privacy, the Commission notes that it is possible to comply with legislative requirements while at the same time recognising the importance of engaging with families. Family-sensitive practice in mental health is a recognised way of working that is underpinned by a person-centered approach in order to empower clients and families with the information, choices and opportunities they need to make fully informed decisions about care, treatment and support. This is an approach that exists in the community and that could equally be practiced in relation to current and former serving members of the ADF, and their families.

The notion of ‘family’ is itself a complex issue. Sometimes a member’s family is not easy to define, and depending on circumstances can include parents, siblings, spouses (legal, de facto and same-sex), children, and an even wider variety of permutations if there are also former spouses and partners. Identifying just who the family is may be more difficult in some circumstances; however, it should not be a reason for not engaging with family.

The need for closer engagement between the ADF and families was a strong message heard throughout the Review. This an avenue that could usefully be pursued by the ADF in order to more clearly identify specific issues experienced by families and to work with families and members to co-design the ways in which these areas could be improved.

## **5. The extent to which former serving members use other services**

The extent to which former serving members use services provided by other parts of government, ESOs, the private sector or non-government organisations is difficult to assess, primarily because there is limited information available about the range and use of such services.

Apart from issues relating to awareness, availability and access (discussed above), the use of other services was addressed in only a handful of submissions and not in any depth in the key informant discussions and group discussions.

Data on service use by former members of the ADF (as well as by current members, and families), is not routinely tracked by services in the general population, nor surveyed in national data collections. Unlike other population groups, such as Aboriginal and Torres Strait Islander people, young people or people looking for work, the Commission is not aware of any general population collections that include identifiers for current serving members, veterans or their family members.

The Commission suggests that further in-depth consideration may be worthwhile regarding the services accessed by former ADF members (as well as by current members and families) outside of those funded by or through DVA (and Defence).

## 6. The reporting and incidence of suicide and self-harm

### Reporting and incidence in the community

Suicide data in Australia are reported in annual Causes of Death publications produced by the Australian Bureau of Statistics. To be recorded as a suicide, either a coronial inquiry must establish that the death was the result of a deliberate act with the intention of ending his or her own life, or the death is subsequently recoded as a suicide by the National Coronial Information System<sup>26</sup>. However, it is important to note these determinations can be difficult, with the result that some suicides are not recognised as such on the official record.

In 2015 (the year for which the most recent data are available), there were 3,027 deaths from suicide in Australia – a rate of 12.6 deaths per 100,000 population.<sup>27</sup> This is the highest recorded number in the past decade and equates to 58 deaths per week. These figures are likely to be underreported because of the stigma and discrimination that surrounds death from suicide and difficulties in confirming the intent of people who have died.<sup>28</sup> Rising rates of suicide in the general population are also being observed in other countries including the USA, China and some member states of the European Union.

The number of non-fatal attempts of suicide is difficult to capture, although it is estimated that approximately 65,000 people attempted suicide in Australia in 2007.<sup>29</sup>

Compared to suicide, information on self-harm is less readily available with no comprehensive population-wide collections of data on deliberate self-harm in Australia.

The most reliable routine collections are the rates of people who are hospitalised for non-fatal self-harm. As noted earlier in this report, suicidal ideation and self-harm are distinct issues, and it is important to recognise that not all people who are hospitalised due to self-harm may have intended to die by suicide. In 2014-15, there were 29,595 hospitalisations due to intentional self-harm. To put these figures in perspective, the most recently available detailed analysis (based on 26,935 cases of hospitalised care due to self-harm in 2008-09) shows that:

- self-harm occurs on average at a rate of around 118 cases per 100,000 population.
- the highest rates of self-harm are in females aged 25-44 years (6,809 per 100,000 population), with the same age group also having the highest hospitalisation rate in males (4,791 per 100,000 population).<sup>30</sup>

These trends are also reflected in other research findings that self-harm is generally seen in younger age groups and more frequently amongst females, with 24% of females and 18% of males reporting they have self-harmed at some point in their lives.<sup>31</sup>

### Comparing suicide and self-harm in serving and former ADF members and the general Australian community

#### *Suicide*

The ADF's Death by Suicide Database includes both confirmed and suspected suicides by current serving full time members of the ADF. According to this data, there were 119 (suspected or confirmed) suicides by current serving members between 2000 and 2016 (as at 30 November 2016).

Data recently released by the Australian Institute of Health and Welfare (AIHW) report that between 2001 and 2014 there were 84 suicide deaths within the full-time current serving population and 66 suicide deaths in the reserve population.<sup>32</sup> These figures reflect confirmed suicide deaths, that is, those which have been confirmed through coronial investigation.

For former serving ADF members and their families, the data is more limited, as DVA insight into this population is constrained to those who are DVA clients or for whom claims are submitted through the DVA system. Between 2001 and 2014, there were 165 claims to DVA by a dependant of an ex-serving member in relation to death by suicide, plus an additional eight claims in 2015 and 2016. The AIHW study reports there were 142 confirmed suicide deaths in the ex-serving population between 2001 and 2014, although it should be noted that suicides amongst those who served in and left the ADF prior to 2001 are not captured by this study.<sup>33</sup>

Overall, the AIHW data show that almost all suicide deaths in the current and former serving population were amongst men. After adjusting for age and when compared with all Australian men, the study found that the suicide rate was:

- 53% lower for men serving full-time
- 46% lower for men in the reserves
- 13% higher for ex-serving men.

When compared to men of the same age, the AIHW data found that suicide rates were:

- 1.9 times as high for ex-serving men aged 18-24 years old
- 1.5 times as high for ex-serving men aged 25-29 years old.

Information contained in the AIHW's preliminary report was not able to identify trends in suicide, as the data shows significant variations in the number of deaths from one year to the next, or to draw conclusions about suicide in any of the three services (Navy, Army or Air Force) or links to length of service or demographic factor such as age and gender. The AIHW report did not collect information about suicide by family members of current or former serving ADF personnel, or have sufficient data to calculate valid comparisons for women.

### *Self-harm*

In relation to self-harm, the evidence around prevalence within the ADF is scarce, as most research has focussed on suicidal ideation and suicide rates. Worldwide, there is considerable variability in rates of self-harm in military and veteran populations. The literature suggests lifetime prevalence rates of self-harm in military personnel and veterans of between 2.3% (compared to a general population rate of 4.9%) and 12.3%, and up to 30% in outpatient mental health care military populations.<sup>34</sup>

Among former serving members and their families, DVA claims data indicate there were a total of 986 hospitalisation events for intentional self-harm from 2000 to 2016.

- Analysis indicates this was for 789 unique individuals, of whom 143 were admitted more than once for self-harm and 35 were admitted three times or more.
- The number of admissions per year has been between 160 and 170, with drops observed in 2015 and 2016.
- The data indicate a wide age range of from 21 to 100 years old, with an overall average age of around 70 years old.

### *Areas for further consideration*

Limitations in the quality and comprehensiveness of data on suicide and self-harm – both in the community and amongst current and former serving members of the ADF and their families in particular – mean that comparisons are difficult. They are also complicated by the need to adjust analyses for age, gender and other factors in order to ensure like-for-like comparisons. Making comparisons regarding suicide and self-harm in the military and general population is therefore a complex task that requires specialised knowledge and technical expertise.

The Commission understands a further report from the AIHW, including more detailed analysis of the preliminary results, will be provided to Government in mid-2017. This report will, where available, incorporate cause of death data from 2015, which will provide a more complete picture of suicide in the serving and ex-serving community. The Commission understands the AIHW will publish their final report in September 2017. Commissioned by DVA, this study draws on the AIHW's National Death Index and Defence's Personnel Management Key System (PMKeyS). While this study is limited to information about people who served in the ADF from 1 January 2001 (when PMKeyS was established), it represents one of the most detailed examinations thus far of suicides in the military population. Additional information about the incidence of suicidality among current and former serving members of the ADF and their families may also be included in the *Transition and Wellbeing Research Programme* findings, which are expected to be presented to Government from mid-2017.

The Commission notes that the true extent of suicide may be underestimated by the data, for both serving and former ADF members and in the general community. It is often not possible to distinguish between an accidental death and suicide, with the reporting of a suicide as an accidental death often helping to lessen the emotional and financial impact on surviving family members.

Ongoing efforts are needed to improve tracking and visibility of needs, uptake and effectiveness of services for current and former serving ADF members and their families. The experience and ultimate outcomes of these services is also critical to informing accountability and continuous improvement. This information is valuable input to service planning by funders such as DVA, Defence, and others working in health, community and veterans service sectors. As also occurs in the broader mental health sector, the development of a strategy for further data development and information priorities within the ADF/veterans context may be a fruitful area for further consideration.

## Recommendations

The Commission advises that these recommendations be considered in light of emerging evidence, particularly the outcomes of the *Transition and Wellbeing Research Programme* being undertaken for Defence and DVA and the *Estimation of incidence of suicide in ex-serving Australian Defence Force personnel* study by the Australian Institute of Health and Welfare.

1. The Minister for Veterans' Affairs and Defence Personnel should further examine how ADF and DVA can best develop a unified system that breaks down the siloed approach experienced by current and former serving members and their families. The goal should be to deliver instead a service offering that meets the needs of individuals in a seamless and person-centred way. Included in the work of this expert panel should be models for commissioning health services across ADF and DVA so that continuity of care for individuals moving from ADF to DVA funded services is maximised; agreeing a process that provides for automatic notification to DVA when a current ADF member suffers a work-related injury (to remove any later requirement to substantiate a work-related injury claim); and implementing processes that ensure contact is made periodically with former members of the ADF and their families to inform them of relevant services and other related information. Any administrative and/or legislative barriers to a unified service offering should be addressed as a priority.
2. As a matter of priority, the Minister for Veterans' Affairs and Defence Personnel should 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.
3. The Australian Government should commission an economic study of the current expenditure (within Defence, Veterans' Affairs, Health, Human Services and Social Services) on health, welfare and disability support for current and former Defence personnel and their families, and consider whether there are superior models for supporting optimal health and wellbeing of current and former members and their families, including models that separate compensation, liability and health care provision. The potential return on investment from achieving improved mental health and wellbeing, and enhanced community and labour force participation, should inform this work.
4. The ADF should continue to invest in leadership training and ongoing cultural change to eradicate any behaviour from within the chain of command that stigmatises mental illness and deters help-seeking behaviour. Dedicated welfare officers and/or peer support workers should be established within each unit to assist the cultural change process and support those who may be at risk as a result of mental health issues or suicidal behaviour.
5. The ADF and DVA should rethink the strategy and range of initiatives to support families. A Family Engagement and Support Strategy should be co-designed with families, and focus on known stress points for families, including transition points. The strategy should also recognise and cater for the diversity of family structures in the ADF and in ex-serving communities.

6. The ADF should review its current approach to implementing family sensitive practices, and implement any necessary changes in policy, practice and training to ensure that services are truly inclusive and family sensitive, particularly in relation to engaging with families when there is a report or incident of self-harm or suicidal behaviour. Any approach that denies involvement of families on superficial privacy and/or security grounds should be vigorously challenged, with a robust process implemented to regularly assess the experience of families in being engaged and participating in health services.
7. The widespread perception that deficiencies exist in the recruitment processes for Defence should be further examined utilising a rigorous methodology to ascertain whether there are points of weakness in the current processes that may lead to unsuitable candidates being accepted for service. In the interests of transparency, both the methodology and the results should be made publicly available and communicated appropriately within the ADF.
8. The current efforts by the Transition Taskforce focusing on supporting the transition of personnel out of the defence forces should continue and aim to deliver an approach to transition that enables all departing personnel to leave with dignity, hope and some certainty about their future, regardless of the circumstances of their discharge. The process of planning for transition should begin on commencement with the ADF, with greater consideration given to the processes that could be implemented during service that would better prepare members for civilian life after their military career. A greater role for peer workers and ESOs to support transition would be desirable, but the ultimate process should be informed by a co-design approach.
9. The ADF and DVA should consider how to better promote the services that are available to current and former serving members and their families so that awareness of the range of services and how to access them is increased.
10. The ADF and DVA should 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). Such options could include self-management, low intensity services, digital services, peer support services or on-base walk-in centres, in addition to specialist clinical services and psychosocial support.
11. The ADF mandatory training on mental health awareness and suicide prevention should be reviewed and strengthened via a co-design process, with the aim of developing training that appropriately contextualises the occurrence of mental illness and educates service personnel on risk and protective factors, the concept of recovery and the benefits of early intervention. Consideration could also be given to training being delivered by peer workers with lived experience of military service and mental health issues or suicidality, possibly in association with an ESO.
12. Independent evaluation of suicide prevention and self-harm services within ADF and DVA is good practice and should be embedded, with the results used to inform further service development. Any new program to reduce the incidence of suicide and self-harm in the ADF or DVA, including services commissioned through ESOs,

must be evidence based and have a clearly defined program of evaluation before the program commences.

13. Further enhancement of specialist mental health expertise within the ADF is recommended, with options including a greater number of military psychiatrists, engagement of mental health nurse practitioners, and more allied health practitioners with clinical mental health expertise (e.g. clinical psychologists). The cost of this enhancement could potentially be off-set by a reduction in outsourced mental health specialist services. Utilising mental health peer workers could complement the expanded clinical professional roles.
14. Consideration could also be given by the Australian Government 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. 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.
15. The ADF and DVA should continue to implement a robust continuous quality improvement framework across all mental health and suicide prevention services, with an annual report to Ministers noting significant achievements in service improvement as well as any challenges.
16. As DVA has mapped the process between lodging a DVA claim, acceptance of a claim, and first payment being made, and established key performance indicators for the time to decision and payment, it should implement a default position, in the event that a decision is not made within the stipulated timeframe, to pay a claimant until such time as a definitive decision is made. This provides an impetus for DVA to ensure that claims are processed in a timely fashion and that claimants are not unreasonably disadvantaged by delays in DVA administrative processes.
17. The ADF should review its approach to serving members whose current mental health issues necessitate a period of alternate duties, and ensure that appropriate and meaningful duties are available that support the well-being and dignity of the member and their recovery.
18. The Minister for Veterans' Affairs should continue to promote the benefit of self-regulation by ESOs offering peer to peer services, utilising a framework that sets out minimum standards. Self-assessment by ESOs against the framework could inform their own quality improvement program and could also form the basis of an approach towards ESOs promoting an enhanced level of evaluation.
19. Continued research is required to develop a comprehensive understanding of suicide and self-harm within current and former members of the ADF, and their families. A long-term research program focussed on mental health and wellbeing, and the prevention of suicide and self-harm should be developed, in conjunction with academics and other research bodies e.g. the National Health and Medical Research Council, the Medical Research Future Fund and the Suicide Prevention Research Fund. This program should be informed by the findings from the Transition and Wellbeing Research Programme and the final report from the AIHW on the



*Estimation of incidence of suicide in ex-serving Australian Defence Force personnel.*  
Two potential areas for research that were raised but not addressed within this review include the veteran prison population and the veteran homeless population.

20. A strategy for further data development and information priorities within the ADF/veterans context should be developed to improve tracking and visibility of the need for, uptake and effectiveness of services for current and former serving ADF members and their families, as well as the experience and outcomes of these services. As part of this strategy, the Australian Government should consider developing a health data identifier for use in health data sets to identify when an individual is a current or former member of the ADF. This would assist in health services planning as well as better targeted service delivery and in research endeavours.
21. De-identified data and other relevant information relating to former ADF members should be provided via the Department of the Health to Primary Health Networks to assist them to consider the needs of former ADF members in the planning and delivery of effective and efficient health services within their regions.
22. 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.
23. Regular reporting on progress in the implementation of the recommendations in this report is required. It is recommended that within six months of receiving this report, and annually thereafter, the Minister for Veterans' Affairs and Defence Personnel table a report in the Parliament of Australia, addressing the actions taken in support of implementing the recommendations, and the progress achieved. It should also include the key issues to be addressed in the next twelve months, and the outcomes expected, as well as the results of key indicators that address the mental health and wellbeing of current and former serving members of the ADF.

# Appendix A: Recommendations of the Independent study into suicide in the ex-service community by Professor David Dunt, January 2009

## PART A Suicide and suicide programs in veterans

### Section 2 Overview of suicide and suicide prevention

**Recommendation 2.1:** In considering the wider focus for Operation Life expressed in the five priority areas, DVA should closely consider the evidence-based literature on suicide prevention and should only implement programs that are evidence-based and most likely to be successful in veterans. These are most importantly doctor education on detection and treatment of depression and restricting access to lethal means.

### Section 3 Review of the research literature on suicide and its risk factors in veterans

**Recommendation 3.1:** It is likely that a study of suicide in a full cohort of post-Vietnam veterans will be conducted at some time in the future. Before making a decision to proceed, there should be a review of findings of:

- the Australian Institute of Health and Welfare investigation into the cause of death of DVA clients by age/sex/conflict with a specific focus on suicide;
- “Preventing suicide: a psychological autopsy study of the last contact with a health professional before suicide” being undertaken by Griffith university;

The former will indicate whether numbers and difference between veterans and non-veterans are sufficient to justify a full cohort study. The latter should further identify likely factors in suicide in Australian veterans.

In addition, any decision will need to take full account of the methodological problems to which veteran suicide studies are susceptible, particularly misclassification of veterans and unadjusted demographic differences between veterans and the comparison group.

### Section 4 Rapid literature review of suicide prevention programs

No recommendations.

## PART B Services for Australian Veterans with mental health problems

### Section 5 Transition from the ADF

**Recommendation 5.1:** The ADF and DVA should have joint responsibility for a comprehensive transition service that works closely with the ADF Transition Centres and extends to at least 12 months post-discharge. It should resolve the duplication in services now being offered by the IPSS and TMS. ADF should fund pre-discharge activities and DVA post-discharge activities within this joint responsibility.

**Recommendation 5.2:** The Lifecycle pilot adds value to existing programs (IPSS/TMS) in improving staff training and support. If successfully evaluated it should be rolled out nationally.

**Recommendation 5.3:** In principle families should have an involvement in Transition programs. This could be at the Transition Seminars involving the Stepping Out program that may need some redesign.

**Recommendation 5.4:** It is important that members leaving the ADF with mental health (or other problems) are fulsomely acknowledged for their contribution to the ADF, particularly so as their health had deteriorated while they were in the ADF. This could take the form of a letter of thanks from CDF or Passing out Parade.

**Recommendation 5.5:** A Keeping in Touch program post-discharge with responsibility jointly by the ADF and DVA extends this healing process. In doing so, it is likely to make an important contribution to the proactive management of any emerging mental health problems.

## **Section 6 Veteran compensation schemes and mental health**

**Recommendation 6.1:** Initiatives such as the Single Claim Form, Separation Health Examination and the Client Liaison Unit are valuable and, subject to satisfactory trialing can be strongly supported. The changing business processes of the MRCA group including a strong orientation to client service are welcomed but should extend to all three schemes, particularly the VEA group and be further strengthened with business, training and evaluation plans. Experienced case managers should be assigned to claims of clients having complex multiple needs claims.

**Recommendation 6.2:** A separate process for claims involving chronic mental conditions should be established involving formal consultation with an appropriate mental health professional (psychiatrist or clinical psychologist) to assess the mental health impact of DVA decisions on veterans at all important decision points (eg primary claims, Section 31 and where relevant VRB and AAT appeals, as well as suspension and downgrading of benefits and CDDA applications. The mental health professional should 'sign-off' for the action to proceed.

It is desirable that the period of the Temporary Special Rate pension (or equivalent) can be extended if the veteran's doctor (or in the event that a doctor is not able to do this, a representative of the veteran) can provide robust evidence of a level of patient distress or risk of self-harm sufficient to render dangerous the conduct of a GARP(V) or GARP(V) M assessment of impairment and lifestyle.

**Recommendation 6.3:** Every VRB hearing for a veteran involving a mental health-related condition should aim to have one member with a clinical mental health background on the two or three member board.

**Recommendation 6.4:** DVA will need to increase its capacity to access psychiatric/clinical psychological advice for both individual cases and policy involving mental health more generally.

**Recommendation 6.5:** In the event that a veteran's claim is incomplete, DVA should consider a further step in the primary application process whereby the application could be returned to the veteran indicating areas where further supporting documentation is the necessary. This would be different in nature to a Section 31 review.

## **Section 7 PTSD and compensation**

**Recommendation 7.1:** Since diagnosing and assessing service connection for PTSD is not straightforward, it would be worthwhile to develop suitable guidelines for this, to supplement the SoPs. It is envisaged that these might involve a suitably qualified clinician taking a structured detailed history that established both diagnosis and possibly exposure to service related and non-service-related traumatic stressors service. This would be conducted at the time of the veteran's health examination in the lead up to the submission of their claim for compensation to DVA.

Until such time as these best practice methods can be decided and instituted and given the difficulties outlined in the use of historical military record sources, it would be better to generally avoid their use. In other words, processes for PTSD should proceed more like other claims. This is as judged by the presentation of material in the veteran's claim and its conformity with the relevant Statement of Principle both in terms of disease causation and service connection based on a reasonable hypothesis that can not be disproved.

**Recommendation 7.2:** The use of historical military service records should move more to the investigation of fraud cases where their use can very clearly demonstrate that a fraud has been perpetrated. Their use should not be routine. If there were particular reasons that they would have value in unusual cases other than for the investigation of fraud, the information needs interpretation and signoff by a mental health professional.

**Recommendation 7.3:** Tip off cases should only be investigated where there is further substantiation and where there are reasonable chances of success. Reliance on anonymous 'informant networks' alone is insufficient to form the basis of subsequent investigation.

## **Section 8 Mental health, compensation & the Ex-Service Organisations**

**Recommendation 8.1:** While volunteer Pension Officers endorsed by ESOs have provided a great community service, it is time to move to a new two-tier system. The first tier would consist of largely volunteer TIP trained Officers as at present. They would in future restrict their advice to straightforward cases.

The second tier would consist of a new group of trained Pension officers and Advocates who would be accredited on the basis of their completion of a Diploma or Certificate IV TAFE qualification. They would be paid through BEST or similar DVA-funded program. They would provide advice to veterans in cases that were not straightforward including appeals and tribunal appearances.

Both groups would be subject to appropriate quality assurance procedures.

Both tiers of Officers would operate with the endorsement of an ESO. The second-tier, paid, accredited Officers would operate on a day-to-day basis more independently of the ESOs so they can provide services both to veterans who align themselves with an ESO and those who do not by reaching out to the veteran.

## **Section 9 Mental health programs and services for veterans**

**Recommendation 9.1:** DVA's mental health strategy beginning in 2001 has led to the development of a number of community mental health promotion programs. DVA intention to consider how this strategy might be further developed is strongly supported. Programs for suicide and alcohol misuse require particular attention. The ACPMH have been

contracted by DVA to evaluate its Mental Health Initiatives for 2007-10 and this will be very useful in identifying other areas.

**Recommendation 9.2:** VVCS is a very successful DVA program that is likely to expand and further develop. Recent developments in Medicare Australia whereby subsidy is now available to psychologists and social workers for counselling are having major impacts and defining new standards for psychologist services. It supports only evidence-based interventions. These are Focused Psychological Strategies for registered psychologists and GPs and Psychological Therapy for clinical psychologists. VVCS should be able to demonstrate that they conform to this standard or how it plans to do so.

It is important that there should be some level of involvement of psychiatrists or GPs with interests in mental health in all VVCS centres. This is because the treatment of DSM-IV mental conditions may require psychotropic drugs which only doctors can prescribe. This involvement could largely take the form of shared care, participation in case conferences and education.

**Recommendation 9.3:** The Hard-to-Engage and Barriers to social and vocational rehabilitation Lifecycle Initiatives undertaken by the ACPMH, on contract with DVA can be strongly supported. The Keeping-in-Touch Initiative (Recommendation 2.5 above), could be extended to offer group proactive health and wellness with possible individual follow-up to veterans and their families.

**Recommendation 9.4:** A strategic review of PTSD programs in Australia should be urgently commissioned. This should be comprehensive in scope and cover service access, acceptability and cost and most successful models of care. Priorities should be defined such that their implementation will have the most effect on the level of patient care ie the programs that are funded will be effective as well as efficacious.

**Recommendation 9.5:** DVA has been very active in supporting and funding research and this can be strongly supported. Its support for evaluation of its innovative programs has been a little less active and could be further developed.

## Appendix B: Recommendations of the Review of Mental Health Care in the ADF and Transition through Discharge by Professor David Dunt, January 2009

### Section 1 Overview

No recommendations

### Section 2 The ADF's Mental Health Strategy

**Recommendation 2.1:** The Directorate of Mental Health needs to be fully staffed and core positions need to be established as triservice rather than on loan by single forces.

**Recommendation 2.2:** An oversight group to the Directorate of Mental Health should be established to consist of senior Defence health, single service health and Defence personnel staff as well as non-Defence clinical and academic experts. The purpose of such a group would be to sustain the strategic direction and delivery of the Mental Health Strategy.

**Recommendation 2.3:** The Mental Health Strategy needs further development for it truly to be a Strategy rather than a small number of specific programs as at present. It should specifically include components in resilience training (including stress inoculation, mental health first aid as well as personal and relationship life skills), mental health literacy and bullying. The Strategy should be evidence-based to the greatest extent possible and the innovative components should be rigorously evaluated. Attention to presentation (marketing) of the revised Mental Health Strategy so as to have maximum impact on ADF members will also be important.

### Section 3 The delivery of mental health services in the ADF

#### *Primary care on bases*

**Recommendation 3.1:** Psychology Support Sections on bases should combine to form teams with health professionals providing mental health care services in medical centres/hospitals and be renamed Mental Health and Psychology Support Services (MHPSS).

**Recommendation 3.2:** Social workers in DCO can have an important role in the delivery of primary care mental services where family issues are involved. They should form part of the proposed multidisciplinary mental health team on base. Their services should be available not only to families of members but members themselves where family issues are involved.

**Recommendation 3.3:** The role of chaplains in primary care mental health services is supported.

#### *Secondary care in regions*

**Recommendation 3.4:** The proposal to create triservice Regional Mental Health Units (RMHUs) can be supported

**Recommendation 3.5:** An important part of the roles of clinical specialists in RMHUs is to visit bases to support primary care mental health practitioners particularly through participation in 'shared care' arrangements and some direct provision of care.

#### *Tertiary care nationally*

**Recommendation 3.6:** The proposal to establish a tertiary-level, triservice inpatient mental health ward within a general hospital facility can in principle be supported but should have lower priority than the rapid and sustained development of high quality primary mental care facilities on bases.

*National planning and operations for mental health services*

**Recommendation 3.7:** The Directorates of Mental Health and Psychology should merge to become the Directorate (or Branch) of Mental Health and Psychology (DMHP) with a SES Band 1 level Director to lead this combined entity.

**Recommendation 3.8:** As previously proposed (Recommendation 2.2) an oversight group to the Directorate of Mental Health should be established to consist of senior Defence health, single service health and Defence personnel staff as well as non-Defence clinical and academic experts. The purpose of such a group would be to sustain the strategic direction and delivery of the Mental Health Strategy.

**Recommendation 3.9:** The Psychology Support Group should be renamed the Mental Health and Psychology Group (MHPSG) and should become multidisciplinary in nature.

#### **Section 4 The ADF mental health workforce – staffing and training issues**

**Recommendation 4.1:** Additional staff should be allocated in the mental health arena accompanied by an increase in APS positions in JHC. Any reallocation under existing staffing caps will see the imposition of deficits in other areas of health care delivery. An overall increase in the Mental Health budget is also necessary in order to deal with critical staffing issues.

**Recommendation 4.2:** Recruitment strategies for CHPs need to offer pay and conditions more attractive to CHPs. They should aim to recruit GPs with a demonstrated interest in mental health.

**Recommendation 4.3:** The use of third party providers (and specifically VVCS) should be considered as providers of mental health services both on and off base.

**Recommendation 4.4:** Options such as telepsychiatry have obvious attractions for the provision of mental health care in remote settings and could operate out of the proposed tertiary level in-patient facility or a RMHU – see Section 3.5.

**Recommendation 4.5:** Psychology assets should be more efficiently deployed by greater use of non-psychologists where this is possible and redesign of post-deployment psychological screening so as to increase the availability of psychologists on base for primary mental health care on base.

**Recommendation 4.6:** A position should be established within the DMH for a relatively junior medical officer to liaise with medical officers in the ADF and promote their involvement and training in primary mental health care.

**Recommendation 4.7:** Pastoral care training for chaplains should be increased.

**Recommendation 4.8:** Expanded initial induction and continuous professional development programs are necessary for medical officers, psychologists and other health personnel aimed at substantially increasing the proportion of mental health staff who are competent to deliver simple cognitive behavioural therapy, care coordination and the management of

non-complex mood and adjustment disorders. Goals for the proportion of staff attending these courses should be set and progress towards these goals should be monitored annually. Appropriate release and travel arrangements will be necessary for this to occur.

**Recommendation 4.9:** AMHOO should be rolled-out – all health staff about to deploy should be required to attend.

### **Section 5 Screening for mental health problems – RtAPS and POPS**

**Recommendation 5.1:** The POPS should retain its present form with additional resourcing so that follow-up and referral for members with possible problems can occur. This will require adequate and timely access to secondary care as well as primary care level mental health professionals. Other desirable new features of the POPS would be an additional brief involving families and an appropriate record system to monitor that follow-up and referral is happening.

**Recommendation 5.2:** It is proposed that only the ‘briefs’ components of the RtAPS be retained. The psychological screen and one-on-one counselling components should be discontinued. The group brief should involve members’ families as well as members and take place on an occasion back in Australia which has both educational and social purposes (eg meeting/talks followed by a BBQ). A suitable name for it would be the Short Returning to Australia Reengagement Program (SRARP).

Resources on base should be increased so that members with early post-deployment problems should have adequate access in the first instance, to primary care level mental health staff.

It is possible to consider that a full second screen could return in the future. It would need to be demonstrated however that one screen has positive benefits for members, that mental health services on base are fully staffed and that there are additional staff to both conduct and properly follow-up two post-deployment screens.

### **Section 6 Military culture and mental health**

**Recommendation 6.1:** Pre-deployment briefings and other annual briefings should include education and training in mental resilience. As these programs are innovative in nature, they need to be evaluated.

**Recommendation 6.2:** Recruit schools should include education and training in mental resilience. Resilience training should also be introduced in promotional and officer courses so that this can later be communicated to lower ranks. Again, as these programs are innovative in nature, they need to be evaluated.

**Recommendation 6.3:** All training, promotional and officer courses should include sessions on mental health literacy and bullying. The presentation of these topics is challenging and needs to move beyond front of classroom ‘briefs’ to be more scenario-based and involve role playing. It should not be so short and embedded among large numbers of briefs to make no impression on members.

Opportunities for even further strengthening Defence Policy in Discrimination and harassment through military discipline or other avenues should be explored.



**Recommendation 6.4:** Paramedics and medical clerks working in Defence medical services should be educated and counselled about the importance that members place on being able to consult doctors in confidence. If education and counselling is insufficient, they should not be able to continue working in Defence health centres, cautioned or disciplined.

**Recommendation 6.5:** For a variety of reasons, Reservists are more likely to experience higher rates of mental health problems post-deployment and experience more difficulties in their recognition and treatment. There should be the same expectation that Reservists attend post-deployment screening and follow-up treatment, if problems are detected, as regular members.

## **Section 7 Privacy, disclosure and sharing of mental health information**

**Recommendation 7.1:** The common multidisciplinary mental health service proposed for what are now separate mental health services should help to promote the sharing of health information among mental health practitioners – see Recommendation 3.11. A common clinical record shared by doctors, psychologists and others is a very important advantage of a common mental health service.

**Recommendation 7.2:** Policy to overcome the non-sharing of health information, as expressed in the recent amendment to DI(G) 16-20 Paragraph 9 and Health Directive 810 should be implemented. In the event of the common multidisciplinary mental health service not proceeding, implementation of this policy should be independently monitored by 12 monthly audit against agreed benchmarks for the next three years. Redress procedures will need to be put in place if benchmark levels are not reached.

**Recommendation 7.3:** (re-presented) Paramedics and medical clerks working in Defence Health Services should be educated and counselled about the importance that members can consult doctors in confidence. Failing that, they should not be able to continue working in health services or disciplined for breaches in Defence medical services.

## **Section 8 The Medical Employment Classification (MEC) system and Mental Health**

**Recommendation 8.1:** Guidelines to guide the application of the MEC system should be developed so as to better define what levels of present or possible future severity of common illnesses (particularly mental illnesses) are compatible with deployability, as determined by their ability to tolerate the withdrawal of medical or care support under operational conditions over a 21 or more day period. The guidelines would be based on, and further extend the Medical Risk Assessment Framework set out in HD 282. The guidelines would be indicative and take into account the clinical discretion in decision-making of the individual doctor assessing an individual member and their circumstances.

**Recommendation 8.2:** The proposed strategy for the development of a policy on the use of anti-depressant medication on deployment is supported.

**Recommendation 8.3:** The concept of differentiating deployment into risk levels should be explored to investigate if it is possible to increase the proportion of members able to deploy at acceptable levels of risk.

**Recommendation 8.4:** The recent trial by the Chief of Army for members, no longer deployable to continue in the ADF in nominated roles such as training has value and should be continued.

## **Section 9 Rehabilitation in the ADF and Mental Health**

**Recommendation 9.1:** The current occupational health model in relation to members with chronic mental conditions needs further development. This will further involve not only the member and the care team, but also their commanding officer.

**Recommendation 9.2:** Support for alternative employment in the member's unit, or elsewhere in their base depends on the mental health literacy of officers as well as other ranks. Rehabilitation for members with chronic mental illnesses including the desirability of alternative employment should therefore be a component of the mental health literacy training in training, promotional and officer training courses, as set out in Section 6.

**Recommendation 9.3:** Participation in on- or off-base rehabilitation programs aimed at returning the member to work is also important. These programs realistically may need to prepare the member for return to work outside the ADF. The principles of rehabilitation (a graduated return to military life which combines both treatment for mental illness and military training) at the former Military Training and Rehabilitation Unit (MTRU) in the UK is worthy of further study.

**Recommendation 9.4:** On-base 'rehabilitation platoons' stigmatise their members and, as a practice should be discontinued.

## **Section 10 Transition from the ADF**

**Recommendation 10.1:** The ADF and DVA should have joint responsibility for a comprehensive transition service that works closely with the ADF Transition Centres and extends to at least 12 months post-discharge. It should resolve the duplication in services now being offered by the IPSS and TMS. ADF should fund pre-discharge activities and DVA post-discharge activities within this joint responsibility.

**Recommendation 10.2:** The Lifecycle pilot adds value to existing programs (IPSS/TMS) in improving staff training and support. If successfully evaluated it should be rolled out nationally.

**Recommendation 10.3:** In principle families should have an involvement in Transition programs. This could be at the Transition Seminars involving the Stepping Out program that may need some redesign.

**Recommendation 10.4:** It is important that members leaving the ADF with mental health (or other problems) are fulsomely acknowledged for their contribution to the ADF, particularly so as their health had deteriorated while they were in the ADF. This could take the form of a letter of thanks from CDF or Passing out Parade.

**Recommendation 10.5:** A Keeping in Touch program post-discharge with joint responsibility by the ADF and DVA extends this healing process. In doing so, it is likely to make an important contribution to the proactive management of any emerging mental health problems.

## **Section 11 Mental health and families in the ADF**

**Recommendation 11.1:** At a broad conceptual level, the ADF needs to welcome the member's family as well as the member into the broad 'Defence family'. Acknowledgement of this in itself is important.

**Recommendation 11.2:** More concrete expressions of this acknowledgement are necessary. These could include participation by families in post-deployment readjustment program (SRARP (see above) and POPS) and pre-deployment briefings (as occurs in the US) as well as transition activities (see Section 10). It could also include attention to family impact on postings and post-deployment exercises and training activities that require members to spend further long periods of time away from their families.

**Recommendation 11.3:** (re-presented) Social workers in DCO can have an important role in the delivery of primary care mental services where family issues are involved. They should form part of the proposed multidisciplinary mental health team on base. Their services should be available not only to families of members but members themselves where family issues are involved.

## **Section 12 Mental Health research and surveillance in the ADF**

**Recommendation 12.1:** The conduct of a prevalence survey of mental health conditions in the ADF should be a high priority. Different options exist and the aim should be to choose the one that best produces robust, useful data and at reasonable cost. If online methods prove suitable for collecting valid and reliable data, they have many obvious advantages.

**Recommendation 12.2:** The ADF's strong commitment to development and evaluation of innovative programs should continue. New programs for members returning from deployment to forward bases with adjustment problems and traumatic stress symptoms should be a high priority for development and evaluation.

**Recommendation 12.3:** The Mental Health Research and Surveillance Advisory Committee has made an important contribution to the Directorate of Mental Health. It should be reestablished as a subcommittee or group of the oversight group proposed for the Directorate of Mental Health.

**Recommendation 12.4:** The PRTG has done valuable work eg the development of the Electronic Psychology Records and Information System (EPRIS). It will increasingly focus on the new directions for mental health taking place the ADF such as the further development and evaluation of the Mental Health Strategy and the delivery of services in multidisciplinary mental health teams.

**Recommendation 12.5:** The decision by COSC to investigate commercial off-the-shelf e-health products to provide a fast-track interim solution to the lack of a comprehensive health information system can be strongly supported. The products should possess the functionality equivalent to what exists elsewhere in the community. This should include occasions of service, diagnosis, quality of life and other psychometric measures of symptom severity at secondary levels of mental health care.

## Appendix C: Members of the Review Reference Group

The following people were nominated by the Minister for Veterans' Affairs to form a Reference Group to provide support to the Commission in conducting the Review.

Name	Organisation
Vice Admiral Russ Crane AO, CSM, RANR	Chair of Prime Ministerial Advisory Council on Veterans' Mental Health
Mr Craig Orme AM, CSC	The Repatriation Commission
Mr John Bale	Soldier On
The Hon Graham Edwards AM	Vietnam Veteran
Brigadier Tim Hanna AM	South Australian RSL Sub-Branch
Major Kelliagh Jackson	Randwick Army Barracks
Major Matina Jewell (Ret'd)	Anzac Centenary Commission
Group Captain Catherine McGregor AM (Ret'd)	Royal Australian Air Force (RAAF)
WO2 Brett Neale	Current serving ADF member
Mrs Anne Pahl	RSL National Representative on the Younger Veterans - Contemporary Needs Forum
Mr Simon Sauer AM, CSC	Mates4Mates
Mr Phillip Thompson	Mental Illness Fellowship North Queensland
Dr Duncan Wallace	Consultant Psychiatrist and Medical Officer, Navy Reserve
Dr Rob Walters	Senior Medical Officer for the ADF, Tasmania Region
Mr David Williams	Bundjalung Man; Royal Australian Navy
Ms Gabrielle Sasse	Defence Families of Australia

## Appendix D: Members of the Australian Advisory Group on Suicide Prevention

Established in mid-2016, the Australian Advisory Group on Suicide Prevention (AAGSP) provides advice to the National Mental Health Commission on system-wide issues related to suicide prevention.

Members are individuals with relevant knowledge and expertise in the issues surrounding suicide and suicide prevention, as well as representatives with a lived experience of suicide from both consumer and carer perspectives.

Name	Organisation
Lucy Brogden	Co-Chair, Commissioner, National Mental Health Commission
Sharon Jones	Co-Chair, Lived Experience Network, Suicide Prevention Australia
Dr Peggy Brown	National Mental Health Commission
Sue Murray	Suicide Prevention Australia
Dr Marshall Watson	South Australia Health
Prof Malcolm Hopwood	Royal Australian New Zealand College of Psychiatrists
Ros Knight	Australian Psychological Society College of Clinical Psychologists
A/A Prof Kim Ryan	Australian College of Mental Health Nurses
Jaelea Skehan	Hunter Institute of Mental Health
Prof John Allan	Safety and Quality Partnership Standing Committee
Natasha Cole	Australian Government Department of Health
Chris Burns	SA Mental Health Commission
Dr Tony Lembke	North Coast PHN
Tim Marney	WA Mental Health Commission
A/Prof Chris Carter	North Western Melbourne PHN
Dr Jane Pirkis	University of Melbourne
Carol Turnbull	Ramsay Health Care
Aine Tierney	Mental Health in Multicultural Australia
Adj A/Prof Jennifer Bowers	Australian Centre for Rural and Remote Mental Health
Prof Patricia Dudgeon	National Mental Health Commissioner
Prof Nicholas Procter	Mental Health Nursing, University of South Australia

## Appendix E: List of services related to the prevention of suicide and self-harm funded through Defence

Name of Service/Program	Year commenced	Brief description of Service/Program	Target Groups
<b>Acute Mental Health on Operations (AMHOO)</b>	2010	The Acute Mental Health on Operations (AMHOO) program is professional upskilling for medics, psychologists, nurses and doctors in the assessment and management of acute mental health presentations in the deployed environment. AMHOO provides the knowledge and practical skills to assess and manage an acute mental health problem or disorder until remission of the condition or the member is evacuated out of the area of operations. AMHOO is a two day course that is mandatory for all ADF Health personnel deploying on operations.	Defence health providers
<b>ADF Alcohol Management Strategy and Plan 2014-2017</b>	2013	The <i>ADF Alcohol Management Strategy and Plan 2014-17 (ADFAMS)</i> sets out a four-year framework for improving alcohol management and reducing the negative impact of alcohol on the health, safety, capability and reputation of the ADF and forms a component of the Defence <i>Pathway to Change: Evolving Defence Culture</i> .	Defence personnel
<b>ADF Alcohol, Tobacco and Other Drugs Program</b>	2011	The <i>ADF Alcohol, Tobacco and Other Drug Program (ADF AToDP)</i> was launched along with the 2011 ADF Mental Health and Wellbeing Strategy with the aim "through workplace education and clinical intervention, to minimise problematic use of alcohol and other drugs amongst ADF members". In support of the overarching <i>ADF Alcohol Management Strategy (ADFAMS)</i> , ADF AToDP offers a comprehensive "stepped care" approach to service delivery for all ADF members, which includes health promotion, early intervention, a range of treatment options, education and training, policy advice and development, and specialist AOD related advice. The ADF AToDP contributes to the literacy, awareness and training for ADF members, the clinical upskilling for mental health professionals and the diagnosis, treatment and rehabilitation of ADF members.	ADF members
<b>ADF Arts for Recovery, Resilience, Teamwork and Skills Program</b>		Following the success of the <i>ADF Theatre Project - The Long Way Home</i> , a unique creative arts program supporting ADF members facing service related health and wellbeing issues utilising music, drama, creative writing and visual arts was developed. Through the medium of the arts ADF members will have the opportunity to tell their story, and the impact on their family, of military service, deployment and returning home, being wounded or injured or becoming ill in service. The program will provide a supportive learning environment to assist individuals in their individual recovery and, for some members, transition to civilian life.	ADF members

<b>ADF Centre for Mental Health</b>	2010	As part of the mental health reform program arising from the Dunt Review, in 2010 Defence established the Australian Defence Force Centre for Mental Health (ADFCMH). The centre is a national operational asset that provides mental health consultancy services, trains and up-skills the mental health workforce, and provides expert advice to Command and ADF members.	Defence mental health professionals ADF Commanders
<b>ADF Health and Recovery Commanders' Guide</b>		This guide aims to assist ADF commanders in meeting Defence's goal of enabling best practice health and rehabilitation services delivered to ADF members before, during and after their recovery from injury or illness. It was designed to inform commanders of the availability of health care and other support programs. It is available electronically on the DRN through the <i>ADF Health and Wellbeing Portal - 'Fighting Fit'</i> .	ADF Commanders
<b>ADF Mental Health and Wellbeing Action Plan 2012-2015</b>	2012	The <i>2011 ADF Mental Health and Wellbeing Strategy</i> provided the blueprint for the development and publication of the <i>ADF Mental Health and Wellbeing Action Plan 2012-2015</i> . The plan articulated Defence' key mental health goals and deliverables, and ensured the recommendations of the Dunt Review were implemented and evaluated.	ADF members
<b>ADF Mental Health and Wellbeing Action Plan 2017-2021</b>	2016	The action plan will outline Defences key mental health goals and deliverables and include how the single Services can contribute to achieving these.	ADF members
<b>ADF Mental Health and Wellbeing Strategy 2011-2016</b>	2011	The strategy's focus is similar to that of the Fourth National Mental Health Plan in that it takes a whole-of-government approach, with a particular emphasis on partnering with DVA to ensure more effective transition for ADF personnel. Specifically, the strategy articulates Defence's vision of achieving capability through mental fitness through a commitment to six strategic objectives achieved by the delivery of programs and services, conducting research and establishing strategic partnerships with relevant departments and organisations.	ADF members
<b>ADF Mental Health and Wellbeing Strategy 2017-2021</b>	2016	The strategy's focus is similar to that of the Fifth National Mental Health and 1st Suicide Prevention Plan in that it takes a whole-of-government approach, with a particular emphasis on partnering with DVA to ensure effective and complementary delivery of services to ADF members. Specifically, the strategy articulates Defence's vision of achieving capability through mental fitness through a commitment to six strategic objectives achieved by the delivery of programs and services, conducting research and establishing strategic partnerships with relevant departments and organisations, and the continuous improvement of programs.	ADF members

<b>ADF Mental Health Awareness Presentation</b>		A mental health general awareness course that aims to provide leaders and commanders with an overview of the support available in the ADF, and delivered upon request.	ADF Members
<b>ADF Mental Health Day</b>	2012	ADF Mental Health Day is an opportunity for all members of the ADF, both full time and part time, to reflect on their own mental health and that of their colleagues, and for commanders and leaders to provide ADF members with the confidence that they and their families will receive whatever support is required. The event is publically endorsed by ADF Senior Leadership, and Joint Health Command, the single Services and the Regional Mental Health Teams organised a range of themed activities conducted during the period 01 to 31 October.	ADF members
<b>ADF Mental Health Fact Sheets</b>	2002	To aid in the mental health literacy, awareness and training for ADF members, a series of <i>Mental Health Fact Sheets</i> are available via the health portal or hard copies in every Defence health facility.	ADF members Families
<b>ADF Mental Health Portal - 'Fighting Fit'</b>	2013	The <i>ADF Health and Wellbeing Portal - 'Fighting Fit'</i> is a web-based resource for all current and ex-serving ADF members and their families, and is available on both the Defence intranet and the Internet. There are also targeted resources for specific personnel and situations, including Commanders, Reservists, ADF members preparing for deployment, veterans, and health professionals. The portal provides direct links to a wide range of Defence websites containing information on ADF health and mental health services and supports, as well as referencing DVA and other reputable external resources.	ADF Members Families Ex-serving members
<b>ADF Mental Health Reform Program</b>	2009	Following the release of Professor David Dunt's Government commissioned independent report into the ADF mental health support services in 2009, titled <i>Review of Mental Health Care in the ADF and Transition through Discharge</i> , the mental health and psychology services provided in Defence have been the subject of planned improvement and reform. Defence has implemented the recommendations of the Dunt Review through a comprehensive ADF Mental Health Reform Program, which commenced in July 2009 and has implemented all of the 52 recommendations.	ADF members
<b>ADF Mental Health Research and Surveillance Plan</b>		The goal of <i>ADF Mental Health Research and Surveillance</i> is to contribute to improvements in the mental health and wellbeing of ADF members by conducting research in support of the ADF mental health and wellbeing strategy, post-deployment screening and mental health and psychology services provided to ADF members.	ADF members
<b>ADF Occupational Military Mental Health and Wellbeing Model</b>	2012	The <i>ADF Mental Health and Wellbeing Action Plan 2012-2015</i> is underpinned by the <i>ADF Occupational Military Mental Health and Wellbeing Model</i> . The model provides the framework for the development of interventions to enhance the mental health and wellbeing of ADF members, whilst recognising that fundamental to strengthening resilience and enabling recovery in a military environment is a shared responsibility for mental health and wellbeing between command, individual ADF members and the health care system.	ADF members



<b>ADF Operational Mental Health Screening</b>	<p>The ADF recognises that war, warlike, peacekeeping and peacemaking operations may expose ADF members to significant risk factors for the development of long-term mental health problems and mental disorders. The ADF therefore provides operationally focused mental health promotion, prevention and early treatment services for all such deployed forces. The aim of <i>the ADF Operational Mental Health Screening</i> is to assist ADF members to deploy, perform their operational duties effectively, and then return to work and private lives with minimum disruption. The current screening includes:</p> <ul style="list-style-type: none"> <li>o a Special Psychological Screen for groups that are considered at high risk of exposure delivered approximately mid-way through the deployment regardless of their actual exposure to potentially traumatic events</li> <li>o a Return to Australia Psychological Screen which is preferably conducted during the week prior to a member leaving the operational theatre</li> <li>o a Post-Operational Psychological Screen is completed between three to six months following the Return to Australia Psychological Screen.</li> </ul>	ADF members
<b>ADF Paralympic Sports Program</b>	<p>The <i>ADF Paralympic Sports Program</i> (ADFPSP) was established in 2010 to support serving ADF members with acquired disability, such as permanent loss of limb function, to adopt an active lifestyle, regain their physical fitness and participate in adaptive sport right through to elite Paralympic sport.</p>	ADF members
<b>ADF Rehabilitation Member and Family Guide</b>	<p>This guide incorporates a Health and Recovery Pathway to demonstrate a typical journey from injury prevention through to rehabilitation, return to duty or transition. It is available through the <i>ADF Health and Wellbeing Portal - 'Fighting Fit'</i> on the Department of Defence web site and on the Defence Restricted Network (DRN). The guide aims to provide information to assist and support seriously wounded, injured or ill ADF members and their families throughout the treatment, rehabilitation and return-to-work journey.</p>	ADF members Families
<b>ADF Suicide Prevention Program</b>	<p>2002</p> <p>Defence has been conducting suicide prevention services since 2002, but these were brought together as a program by the 2011 ADF Mental Health and Wellbeing Strategy. The ADF Suicide Prevention Program is a core component of the 2017-2021 Mental Health and Wellbeing Strategy. This program has a comprehensive approach across the organisation and includes: ADF administration and health policy guidance on managing self harm, harm to others and suicide; the monitoring of the number of confirmed or suspected deaths by suicide by full-time ADF members; conducting clinical reviews on ADF members who have died by suicide for quality assurance and continuous improvement purposes; the provision of risk assessment training to Defence mental health professionals; the training of Defence managers and supervisors in the identification and management of suicidal behaviours and mental health problems in the workplace; and annual suicide prevention and mental health awareness training for all Defence members.</p>	Defence personnel

<b>ADF Theatre Project – “The Long Way Home”</b>		Over 2013/14 Defence developed an innovative performing arts project in partnership with the Sydney Theatre Company. The aim of the project was to assist with the rehabilitation and recovery of ADF members who have been wounded or injured, or become ill in service. This unique project also provided the Australian community an opportunity to understand the ADF’s experience on operations over the last decade.	ADF members
<b>Alcohol, Tobacco and Other Drugs Awareness Presentation</b>	2002	Alcohol, Tobacco and Other Drugs (AToDS) Awareness training is the Level 1 component of the ADF Alcohol, Tobacco and Other Drugs Program and is a mandated annual awareness presentation for all Defence personnel and provides basic awareness training. It is available via face-to-face or CAMPUS. The 2016 training is available for use and a revised 2017 version will be released for the start of the annual training cycle.	Defence personnel
<b>Applied Suicide Intervention Skills Training</b>		The third level of suicide prevention training (SPT) encompasses suicide first aid gatekeeper training in the form of Applied Suicide Intervention Skills Training (ASIST). Unlike Level’s 1, 2 and 4 SPT, ASIST is a commercial suicide prevention training package. It was developed by LivingWorks and is an internationally regarded program. ASIST provides participants with the skills to identify at-risk individuals, and facilitate safety planning and access to mental health support. Within Defence, ASIST is primarily targeted at junior leaders, commanders, managers, health professionals and Chaplains.	Defence personnel
<b>Army Industry Partnership Initiative</b>		Complementary to the <i>Rehabilitation through Employment Initiative</i> is <i>Army’s Industry Partnership Initiative</i> . This initiative is aimed at working with defence and other industries, with other government departments, and with charitable and non-charitable organisations, including recruitment consultants, to identify training, development and placement/employment opportunities for wounded, injured or ill soldiers.	ADF members
<b>Army Rehabilitation through Employment Initiative</b>		Army, through its <i>Rehabilitation through Employment initiative</i> , is providing pathways to employment for medically separating soldiers. Army has been engaging stakeholders from RAAF, RAN, wider Defence, other government departments (including DVA and ComSuper), Defence industry, recruitment consultants and ex-service organisations in order to develop this program.	ADF members
<b>Assessment &amp; Case Formulation</b>	2013	The Assessment and Case Formulation program is clinical professional upskilling for the Defence mental health workforce. It was developed by the ADF Centre for Mental Health in partnership with Phoenix Australia and provides the knowledge and skills to conduct a comprehensive mental health assessment and develop a formulation to support an appropriate pathway to care for ADF members presenting with mental health problems.	Defence mental health professionals

<b>BattleSMART</b>	2009	BattleSMART is a comprehensive whole of career resilience training program introduced in 2009. Designed as a modularised educational program, it operates across the ADF, teaching and refreshing resilience training at key points throughout a member's career. It is a preventive program designed to enhance an individual's ability to cope effectively with increased stress and adverse or potentially traumatic events in their lives.	ADF members
<b>Case Management Project</b>	2014	The Case Management Project was established to implement a Garrison Health Operations national Health Care Coordination Model to provide a standardised and nationally consistent approach to patient management and oversight for cases that are complex and/or where high level coordination and situational awareness is required. The key element of the model is the Health Care Coordination Forum (HCCF)	ADF members
<b>Chief of Army Wounded Injured and Ill Digger Forum</b>		The Chief of Army hosts an annual Wounded, Injured and Ill (WII) Digger Forum. The Wounded Diggers Forum provides WII Army personnel and their families with a wide range of information on support organisations and benefits. The forum is an avenue for exchange of information and ideas between Army and it's broader family, enabling WII members and their families to provide feedback on key issues and concerns of members and families in the immediate aftermath of injury. The last Chief of Army Forum was held in Canberra on Nov 2015. The focus was on non-operational injuries and illnesses and examination of the effectiveness of Army's processes across the rehabilitation-transition continuum.	ADF members Families
<b>Clinician Administered Posttraumatic Stress Disorder Scale (CAPS)</b>	2011	The Clinician Administered Posttraumatic Stress Disorder Scale (CAPS) program is clinical professional upskilling for the Defence mental health workforce. The CAPS is a diagnostic psychometric instrument used to inform the assessment, treatment and management of ADF members presenting with PTSD. The CAPS program was developed by the ADF Centre for Mental Health.	Defence mental health professionals
<b>Cognitive Processing Therapy (CPT)</b>	2014	The Cognitive Processing Therapy (CPT) program is professional upskilling for senior Defence mental health clinicians in the delivery of an evidenced based treatment protocol for Posttraumatic Stress Disorder. The ADF Centre for Mental Health partnered with Phoenix Australia to develop the program.	Defence mental health professionals
<b>Commanders and Mental Health</b>		An interactive workshop about the role of commanders and leaders in the management of mental health, delivered by Defence mental health professionals to all single-Service pre-command courses and annually at the joint Australian Command and Staff Course.	ADF Commanders
<b>Comprehensive Soldier Fitness Program</b>		Provided to Air Force members, the program is designed to increase psychological strength and positive performance and to reduce the incidence of maladaptive responses. Based on the principles of positive psychology, used as complimentary resilience training.	Air Force members

<b>Critical Incident Mental Health Support (CIMHS)</b>	2005	Critical Incident Mental Health Support (CIMHS) refers to a process of intervention provided to individuals who have been involved, either directly or indirectly, in a Critical Incident or Potentially Traumatic Event, either in garrison or on deployment. CIMHS is designed to bolster individual and group resources in order for personnel to maintain performance throughout incidents, and to return to duty and perform to their full capacity as quickly as possible. CIMHS contributes to the literacy, awareness and training for ADF members and the clinical upskilling of mental health professionals.	ADF members
<b>Critical Incident Mental Health Support (CIMHS) for Commanders</b>	2005	This training is designed to education commanders (LCPL (e) and above) on the CIMHS process and what support they can expect to receive after a critical incident.	ADF Commanders
<b>Critical Incident Mental Health Support (CIMHS) Peer Advisor</b>	2005	This two-day course provides Ship Warrant Officers (SWO), Chief of Boats (COB) and Clinical Managers (Medics) with the knowledge and skills required to perform the CIMHS Peer Advisor role on a Major Fleet Unit or submarine. The role of CIMHS peer advisor is unique Navy. Their role is to support Command in the immediate aftermath of incidents where mental health professionals are not readily available. CIMHS Peer Advisors are trained to promote engagement in the CIMHS process, assist personnel experiencing mental health problems, provide unit liaison with CIMHS responders and provide basic CIMHS framework advice to Command.	Navy members
<b>Defence DVA MoU</b>	20113	Memorandum of Understanding between Defence and DVA which supports joint and collaborative work in areas such as improved information sharing, research into mental health and rehabilitation, transition services, mental health promotion and education online resources and access to services of the Veterans and Veterans Families Counselling Service.	ADF members
<b>Defence VVCS AfS</b>	2013	The Agreement for Services (AfS) enables referral by Defence of ADF personnel to the Veterans and Veterans Families Counselling Service (as a Service Provider) independent of eligibility under the Veterans Entitlement Act or the Military Rehabilitation and Compensation Act, on a fee for service basis.	ADF members

<b>Family Inclusive Post Operational Psychological Screening</b>	2011	Defence conducted a trail of Family Inclusive Post-Operational Psychological Screening in Darwin, Townsville and Brisbane. The Family Inclusive Post-Operational Psychological Screen was developed to assist the member and their families in the reintegration from deployment and an invitation to attend the session was provided to the member's family. For the trail, Defence mental health professionals were clinically upskilled with Family Sensitive Practice Training, developed by the Bourverie Centre, La Trobe University, in order to provide this family intervention. Although the uptake by family members was extremely low, the mental health professionals were able to utilise their family sensitive skills by 'virtually' bringing the family into the session. Family Inclusive POPS remain an option for service delivery by trained mental health professionals, however the majority of demand for this service is for family sensitive POPS.	ADF members Families
<b>Force and Family program</b>		The Force and Family Program holds carriage of all Seriously Wounded Injured and Ill Programs (SWIIP) within SOCOMD. Their aim is to empower members and their families during the recovery period by providing support to unit level initiatives, processes and networks. By ensuring family involvement, duress on the member is lessened and positive outcomes are more likely.	SOCOMD members
<b>Intensive Rehabilitation Teams (IRT)</b>		The <i>Intensive Rehabilitation Team (IRT)</i> is the clinical rehabilitation capability which fills a void between the specialist rehabilitation services available through public/private partners and the general restorative therapies available through Garrison Health. The IRT is in Holsworthy where it has provided the specialists needed to generate an intensive, individually tailored rehabilitation program for members in an out-patient environment.	ADF members
<b>Keep Your Mates Safe - Low Risk Drinking</b>		This is the second component of the ADF Alcohol, Tobacco and Other Drugs Program and is aimed at personnel who regularly socialise & drink alcohol. It is an education workshop that informs members how to keep themselves and mates safe / safer when out drinking.	ADF members
<b>Keep Your Mates Safe - Peer Support Network</b>		The <i>Keep Your Mates Safe (KYMS)-Peer Support Network</i> is intended to address stigma associated with mental health problems, increase awareness of support services available to ADF members and provide participants with practical skills to assist themselves and others to take action if a mental health problem is identified. The <i>KYMS-Peer Support Network</i> contributes to the literacy, awareness and training for ADF members.	ADF members
<b>Keep Your mates Safe - Suicide Prevention Training</b>		Keep Your Mates Safe (KYMS) – Suicide Prevention Training is the Second Level of Suicide Prevention Training in the ADF Suicide Prevention Program. This training is designed for all Defence members, targeting peers, junior leaders and commanders and managers, with the goal of enabling them to identify persons at risk of suicide and direct them to first aid and health resources. It can be provided as a separate workshop or as a component of the KYMS-Peer Support Program. This training is currently being revised to ensure the currency of the content for 2017.	ADF Members

<b>Living with Disability - Families Stronger Together residential workshop pilot</b>		The workshop content was developed and delivered by Veterans and Veterans Families Counselling Service (VVCS) under the terms of the Agreement for Services. It was designed to enhance the ability of families to support ADF member rehabilitation through provision of a residential workshop and follow day to members living with disability and their family. Content of the workshop includes cohort-building, communication, anger management and other sessions designed to strengthen the family unit and support both member and family in coping with disability and the rehabilitation process.	ADF members families
<b>Mate-to-Mate Peer Visitor program</b>		The <i>'Mate to Mate' Peer Visitor program</i> is designed to create a training, selection and support framework for appropriate peer support to be provided by a current or retired ADF member (peer visitor) to a seriously ill, injured or wounded ADF member. The pilot has provided a framework for informal visitation to occur between a peer visitor, trained in psychosocial awareness, and an ADF member who needs a network of support for their rehabilitation.	ADF members
<b>Meaningful Engagement Options</b>		There are times when a member on an ADF rehabilitation program is deemed clinically fit by their Defence Medical Officer to return to work, however, suitable duties in their unit or an alternate unit are not available. In these cases the Rehabilitation Consultant will use Meaningful Engagement Options, the active engagement of a member in activities that are meaningful to them, to promote and maintain physical, cognitive and emotional health.	ADF members
<b>Member Support Coordination</b>		A supporting component integral to the provision of SWIIP, is the <i>Member Support Coordination</i> , consisting of the overall coordination effort required to ensure that an ADF member experiencing a complex case is effectively supported throughout their recovery, rehabilitation and return to work or transition.	ADF members
<b>Mental Health Workforce Supervision Framework</b>	2016	The Mental Health Workforce Supervision Framework is currently under development by the ADF Centre for Mental Health. When operational, it will provide the structure and resources to provide a co-ordinated and standardised pathway to clinical supervision for all mental health professionals working in garrison and on operations. The framework will be supported by the clinical governance resources of JHC and implemented through the RMHT nationally.	Defence Mental Health Professionals
<b>Mental Health Workforce Training Continuum</b>	2016	The Mental Health Workforce Training Continuum outlines and mandates the training requirements for all members of the Defence mental health workforce to deliver mental health services in garrison and on operations. The integrated workforce is comprised of ADF, APS and Contracted Service Provider personnel and is inclusive of all disciplines of mental health including medicine, nursing, psychology and social work. The continuum divides the training into core competencies, specialised training, training for trainers and continuing professional development training and is supported by the platforms of the Defence Learning Branch.	Defence Mental Health Professionals

<b>Mental Health Advisory Group</b>	2012	The implementation of the <i>ADF Mental Health and Wellbeing Action Plan 2012-2015</i> is overseen by the <i>Mental Health Advisory Group</i> which meets three times a year. Membership of this group includes senior representatives of Joint Health Command, Mental Health Psychology and Rehabilitation Branch, State, Territory or Commonwealth Health Department, mental health research and academia, and the ADF Families Association.	ADF members
<b>Mental Health and Psychology Sections</b>	2012	Mental health and psychology support is predominantly provided to ADF members through the Mental Health & Psychology Sections (MHPS) located on all major bases around Australia. The Mental Health & Psychology Sections are staffed by a mix of military, APS and contracted mental health professionals. They offer a range of services which include clinical assessment and treatment, and facilitate referrals to external specialist service providers as required.	ADF members
<b>Mental Health and Psychology Service Delivery</b>	2012	Early identification and access to treatment and rehabilitation for mental health issues are key priorities for Defence. Garrison Health Operations is primarily responsible for the delivery and management of quality, safe, efficient and effective health care to ADF members within Australia and on non-operational postings overseas. Garrison Health facilities provide access to treatment and rehabilitation through a multidisciplinary holistic approach which includes medical officers, specialists, physiotherapists, mental health providers and rehabilitation consultants.	ADF member
<b>Mental Health and Psychology Service Delivery Model 2012</b>	2012	The <i>Mental Health and Psychology Service Delivery Model 2012</i> is a set of core principles, based on the strategic objective “Delivery of comprehensive, coordinated, customised mental health care” from the <i>2011 ADF Mental Health and Wellbeing Strategy</i> , that inform and guide the delivery of ADF mental health and psychology services.	ADF members
<b>Mental Health and Wellbeing Continuous Improvement Framework</b>	2015	As part of the commitment to continuous improvement, an external evaluation of the complete range of programs and services was conducted in 2015 by Phoenix Australia - Centre for Posttraumatic Mental Health. The aim of this evaluation was to conduct an assessment of ADF Mental Health programs and services to determine their level of readiness for evaluation and obtain the information required to develop an over-arching Continuous Improvement Framework (CIF). The CIF will be implemented in 2017.	ADF members
<b>Mental Health First Aid - Australia</b>		The Mental Health First Aid course (Developed by MHFA Australia under Commonwealth funding grant) is delivered to SOCOMD personnel over a two day period. The aim of the course is to improve mental health literacy amongst SOCOMD members, as well as improve skills for early identification and supporting members with mental health issues. Courses are scheduled into natural breaks in Unit training programs with an intent to train and re-qualify SOCOMD personnel every 3 years.	SOCOMD members

<b>Mental Health Help Lines</b>	2003	<p>Available to ADF members and their families are a range of helplines that provide a triage service inclusive of mental health concerns. These helplines include:</p> <ul style="list-style-type: none"> <li>• <b>1800 IM SICK.</b> A national 24 hour, seven day a week, call service providing triage and health support for serving ADF members within Australia provided by Medibank Health Solutions under the ADF Health Services Contract. This helpline assists ADF members to obtain health care if they become ill or injured after hours or are not in close proximity to an On-Base health facility.</li> <li>• <b>All-Hours Support Line.</b> This helpline provides a confidential 24 hour, seven day a week, mental health triage, referral and advice service for serving ADF members and their families.</li> <li>• <b>DCO Defence Family Helpline.</b> This helpline provides assistance to ADF families, including ADF members, to access a broad range of services and information, including mental health support.</li> </ul>	ADF members Families
<b>Mental Health Integration Project</b>	2014	<p>The Mental Health Integration Project (MHIP) was established and has worked to ensure the key principles of the Mental Health and Psychology Service Delivery Model (MH&amp;P SDM) are implemented in accordance with best practice and with national consistency in all JHC health facilities. The project has translated this model into a revised and nationally consistent framework for provision of mental health and psychology services within JHC health facilities. In doing so, JHC is embedding mental health care into the primary health care setting when caring for ADF members.</p>	ADF members
<b>Mental Health Mobile Applications</b>		<p>In a joint initiative between Defence and DVA a series of mobile applications have been developed for ADF members and their families and are available for downloading through the internet. The mobile applications currently available are:</p> <ul style="list-style-type: none"> <li>• <b>High Resilience Application.</b> Aims to help manage symptoms of stress, build resilience and optimise performance. The skills provided are based on the BattleSMART principle</li> <li>• <b>PTSD Coach Australia.</b> This application aims to inform about and manage symptoms that commonly occur after exposure to trauma.</li> <li>• <b>ON TRACK with the Right Mix.</b> This application is designed to help keep track of the number and types of alcoholic drinks consumed and how much they cost, and provides information on how this consumption will impact on wellbeing and fitness.</li> </ul>	ADF Members Families Ex-serving members



<b>Mental Health Risk Assessment Training (MHRAT)</b>	2016	The Mental Health Risk Assessment Training (MHRAT) program is mandatory professional upskilling for all mental health professionals working in Defence, including Medical Officers, Psychologists, Mental Health Nurses and Social Workers. MHRAT is a one day program that provides the knowledge and skills for the assessment and initial management of members presenting with risks of suicide, self harm and/or harm to others. MHRAT replaces the Suicide Risk Assessment Training (2012 - 2015)	Defence mental health professionals
<b>Mental Health Screening Continuum Project</b>	2016	The <i>Mental Health Screening Continuum</i> project will implement a range of new initiatives to expand the current screening framework from a model based on operational deployment or trauma exposure to an ADF comprehensive model for all members. This includes a Command requested screen and a periodic screen for those members that have not been otherwise screened for 12 months or more.	ADF members
<b>Mental Health Screening Training</b>		Mental health screening training is provided to all required Defence mental health professionals and other identified non-mental health professionals such as Examiners Psychological to enable early identification of the development of long-term mental health problems and mental disorders and ensure that the member is referred for early treatment services.	Defence Mental Health Professionals Examiners Psychological
<b>Mental Status Examination (MSE)</b>	2013	The Mental Status Examination (MSE) program upskills the Defence mental health workforce in the conduct of a mental status examination. The program provides the necessary knowledge and skills to assess mental status and document results in a standardised format as a fundamental component of a comprehensive mental health assessment.	Defence mental health professionals
<b>Monitoring of Outsourced Recruitment Psychology Services</b>	2002	Ongoing quality assurance oversight of professional work conducted by outsourced recruitment psychology services. Biannual reporting of compliance of outsourced recruitment psychology services against seven key performance indicators, including internal and external audits.	ADF candidates
<b>Motivational Interviewing (MI)</b>		The Motivational Interviewing (MI) program is professional upskilling for the Defence mental health workforce. MI is a therapeutic approach that facilitates and engages with intrinsic motivation in order to effect behaviour change. It is a client-centred and goal directed form of therapy that has broad application with ADF members presenting with mental health problems.	Defence mental health professionals

<b>Navy Pre-deployment Brief</b>	2005	The Navy Pre-deployment Brief is delivered to ships prior to an operational deployment. The group-delivered Pre-deployment Brief is 1.5 hours in duration. The brief covers the following areas: (1) Realities of the operation, including operational tempo, communication with family; potential challenges, potentially traumatic events and coping mechanisms; (2) Overview and application of the BattleSMART (resilience) model; and (3) Mental Health and Psychology support services and resources.	Navy members
<b>Operation RESOLUTE Mental Health program</b>	2011	The Operation RESOLUTE Mental Health program comprises a biennial group-delivered Resilience brief and an annual Mental Health and Wellbeing Questionnaire (MHWQ). Following administration of the MHWQ, a screening interview is conducted by a Psychologist.	Navy members
<b>Operation RESOLUTE Resilience Brief</b>	2011	The Operation RESOLUTE Resilience Brief is delivered to Navy crews assigned to RESOLUTE. The group-delivered Resilience Brief is 1.5 hours in duration. The brief covers the following areas: (1) Realities of Operation RESOLUTE, including operational tempo, communication with family; potential challenges and body recovery; (2) Overview and application of the BattleSMART (resilience) model; and (3) Mental Health and Psychology support services and resources.	Navy members
<b>Organisational Climate Surveys</b>		Concurrent with initiatives to address individual mental health, the <i>ADF Mental Health and Wellbeing Action Plan 2012-2015</i> also provides tools that enable Commanders and Managers to focus on organisational climate. Clear links have been demonstrated between organisational constructs such as, morale, cohesion, leadership and communication and subsequent individual wellbeing and performance measures. Unit/Ship Commanders are generally encouraged to monitor organisational climate through internal-to-unit mechanisms, for example, leave audits, attrition, discipline concerns, medical centre attendance and personal review boards. Where required, however, external-to-unit consultancy can be used to provide a more independent, comprehensive view of a Unit's social climate. The most commonly used standardised method in the Garrison (non-deployed) environment, is a targeted survey tool called the PULSE (it was previously spelled out in full as the Profile of Unit Leadership, Satisfaction, and Effectiveness). Another version of the PULSE designed specifically for the use in an operational environment is the Human Dimension of Operations (HDO) survey. The HDO has been utilised infrequently in an ADF context.	ADF Commanders
<b>Outpatient Alcohol Treatment Program (OATP)</b>		The Outpatient Alcohol Treatment Program (OATP) is the fourth component of the ADF Alcohol, Tobacco and Other Drugs Program. It is a four day group treatment program which aims to inform members on strategies to reduce alcohol intake to safe levels. This program is useful for members who believe their alcohol use is starting to cause problems with their work performance, relationships, health or civil/military disciplinary issues e.g. DUI.	ADF members

<b>Regional Mental Health Team - Promotions Officer</b>	2012	RMHT Promotions Officers are responsible for coordination and delivery of ADF member training and professional upskilling at regional locations. There are also involved in the facilitation of professional networks both within and external to Defence to enhance delivery of mental health services.	ADF members Defence mental health professionals
<b>Regional Mental Health Team - Senior Mental Health Professional</b>		The Senior Mental Health Professional provides supervision to mental health professionals in their region with regards to complex cases, conducts clinical assessments, coordinates peer consultation meetings and is responsible for auditing the Mental Health and Psychology Sections on a quarterly basis.	Defence mental health professionals
<b>Regional Mental Health Teams</b>	2012	Regional Mental Health Teams were established to ensure all major areas had a central point of contact and access to mental health providers who could assist in the coordination and delivery of clinical services that are outside the scope of the Mental Health and Psychology Sections.	ADF members
<b>RESET</b>	2014	RESET is an early intervention mental health program developed by the ADF Centre for Mental Health in conjunction with Phoenix Australia. RESET runs across six modules in a two day group program format. It utilises a self management approach in coaching participants to build skills across a range of quality of life domains including wellbeing, health, family, workplace and social connection. RESET builds on the mental health and wellbeing literacy developed across the suite of Keep Your Mates Safe (KYMS) programs and compliments the themes of self management and skills building applied during the BattleSMART continuum. RESET sits in the mental health service delivery landscape between awareness raising and therapeutic intervention by building practical strategies to manage challenge and adversity with confidence. RESET is designed culturally for the current serving ADF population, is informed by a robust evidence base and is delivered by experienced Defence mental health professionals. RESET is positioned in the resilience space, in the rehabilitation and recovery framework, in the decompression and reintegration phase of the deployment cycle and in the transition space.	ADF members

<b>Second Opinion Clinic at the ADF Centre for Mental Health</b>	2011	The aim of the Second Opinion Clinic is to provide specialist assessment and management recommendations for current serving members with complex, treatment resistant, mental disorders. The clinic provides a national service through its tele-mental health capability and conducts assessments via video-conferencing link to regions around Australia and overseas. Assessments are conducted by a joint team of Psychiatrist and Psychologist. The clinic provides comprehensive, forensic style reports that include diagnosis, formulation, sequenced management plans, advice on employability / deployability and retention in the ADF. The Second Opinion Clinic is a tertiary referral clinic and does not provide an initial specialist assessment service nor does it assume the ongoing management of members.	ADF members
<b>Selection Test Reviews</b>	2013	To ensure the right people are selected for the right jobs, military personnel selection procedures and tests are being systematically reviewed and checked for fairness, reliability, and compliance with appropriate professional standards.	ADF members
<b>Soldier Recovery Centres</b>		The <i>Soldier Recovery Centres</i> are an Army initiative and have established by Army in Darwin, Townsville, Brisbane and Holsworthy to support the recovery of wounded, injured or ill soldiers. Their aim is to provide a positive recovery environment where ADF members are engaged in meaningful activities and are able to focus on their recovery.	ADF members
<b>Spiritual Process and Resiliency Trauma Association (SPARTA)</b>		SPARTA (Spiritual Process and Resiliency Trauma Association) program is a 5 day course run by facilitators from the US and designed for SOCOMD members with Post Traumatic Stress Disorder, non-responsive to first-line treatment. It uses a range of mindfulness techniques such as meditation and reflection, as well as equine therapy, adventure training, and counselling. A trial was conducted in Jan 16 and a confirmatory trial will be held in July 16.	SOCOMD members
<b>Suicide Prevention Awareness Presentation</b>	2002	Suicide Prevention Awareness training is the Level 1 training component of the ADF Suicide Prevention Program. This training is a mandated annual awareness presentation for all Defence personnel and provides basic awareness training. It is available via face-to-face or the Defence online training system.	Defence personnel
<b>Support to Wounded Injured or Ill Program</b>		The <i>Support to Wounded, Injured or Ill Program</i> (SWIIP) is a joint Defence and DVA program that aims to facilitate the effective management of seriously wounded, injured or ill ADF members through a framework within which members are provided the support needed to recover. The needs of a seriously wounded, injured or ill ADF member and their family necessitates the coordinated and focussed efforts of the chain of command and supporting agencies to ensure that every member returned to the workplace contributes to ongoing capability.	ADF members

## Appendix F: List of services related to the prevention of suicide and self-harm funded through DVA

Note: this table does not provide details on the services available via DVA's health card arrangements (i.e. White Card and Gold Card for mental health treatments and the Orange Card for pharmaceuticals), which constitute the large majority of funding provided by DVA for mental health services.

Name of Service/Program	Year commenced	Brief description of Service/Program	Target Groups
<b>ADF Post-Discharge GP Health Assessment</b>	2014	Any former serving ADF member is able to access a post discharge health assessment by a GP that can assist in the early identification of mental health issues. A Medicare rebate is available for this assessment. A key objective is to help GPs identify and diagnose the early onset of physical and/or mental health problems among former serving ADF members. In supporting this, DVA has funded the development of a specifically designed screening tool. This tool includes screening tools for alcohol use, substance use, posttraumatic stress disorder and psychological distress, as well as information on how to access other DVA services that their patient may be eligible for.	Ex-serving ADF Members
<b>At Ease Mental Health Portal (Desktop and Mobile)</b>	2013	At Ease is DVA's mental health portal offering mental health and wellbeing information and resources for veterans and serving personnel, their families, friends and carers as well as health providers. The original At Ease website was redeveloped in 2013 into a mental health portal, bringing together a number of DVA mental health and wellbeing websites. The At Ease portal includes a range of YouTube videos with real life veterans and families talking about mental health and access to a range of mobile applications.	Current Serving ADF Members Ex-serving ADF Members Family Health Providers
<b>At Ease: Serving, ex-Serving and Reservist ADF personnel, Veterans and Families Website (Desktop and Mobile)</b>	2008	The At Ease website is DVA's primary mental health website to help serving and ex-serving Australian Defence Force personnel, and their families, recognise the symptoms of poor mental health, find self-help tools and advice, access professional support, learn about treatment options and get advice for family members.	Current Serving ADF Members Ex-serving ADF Members Transitioning Members Family

<b>Beyond the Call</b>	2009	Beyond the Call is a book of stories that celebrates the experiences and resilience of veterans with mental health and/or substance abuse issues, and the way in which their partners and families have supported them. This collection of eight individual stories, told from different perspectives, increases awareness of the breadth of experiences of Australia's veteran community. Beyond the Call assists in improving understanding of the challenges faced by veterans and their families. It is a valuable resource for veterans and families and the healthcare providers who treat them.	Current Serving ADF Members Ex-serving ADF Members Family
<b>Cooking for One or Two</b>	2000	The 'Cooking for One or Two' program is designed to improve confidence in preparing a variety of health meals using easy cooking techniques. The program includes five sessions and can be conducted by a facilitator who does not require any formal cooking qualifications. The program focuses on areas such as equipment and utensils, personal hygiene and food handling rules, meal plans and health information. The programmes can be offered to individuals or a group.	Ex-serving ADF Members
<b>Coordinated Client Support</b>	2010	Part of the government's response to the <i>Independent Study into Suicide in the Ex-service Community</i> was the implementation of a case coordination system for clients with complex and multiple needs. Case coordinators assist at-risk clients with complex needs to navigate DVA services and benefits in order to minimise their risk of self-harm and maximise their quality of life. Coordinators also provide a primary point of DVA contact for clients and assist them and their families with other psychosocial needs external to DVA to help them enhance their quality of life. The coordinators act as the primary contact point for the client and consenting third parties (eg doctors and counsellors). The Department received additional funding in the 2015 Budget as a result of a New Policy Proposal to enhance DVA's Case Coordination program, improving the level of support and early intervention assistance provided to veterans with complex and multiple needs, such as those at high risk and/or with mental health conditions.	Current Serving ADF Members Ex-serving ADF Members Family Health Providers
<b>Day Club Programs</b>	1993	Day clubs are operated by ex-service or community organisations and generally are attended by older people. They are open to veterans and the general community. The clubs aim to reduce social isolation and offer a program of health-enhancing activities.	Ex-serving ADF Members Ex-service Organisations
<b>Heart Health Program</b>	2001	The Heart Health Program aims to increase physical health and wellbeing through practical exercise, nutrition and lifestyle management support. It is a 52 week program and includes two physical activity sessions per week and 12 health education seminars. It can be offered as a group or individually-based program.	Eligible ex-serving ADF Members

<b>HighRes App</b>	2015	A self-help smart phone app to help serving and ex-serving ADF personnel, and their families, manage stress 'on the go' and build resilience over time. The website was tested with serving and ex-serving ADF members.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations
<b>HighRes Website</b>	2015	The High Res website offers interactive tools and self-help resources to help users cope better with stress, build resilience and bounce back from tough situations. The website also provides an Action Plan where users can develop a resilience plan, set goals and track their progress. The High Res was developed in collaboration with Defence and is based on the ADF's BattleSMART (self-management and resilience training) program. The website was tested with serving and ex-serving ADF members.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations
<b>Men's Health Peer Education</b>	2001	The aim of the Men's Health Peer Education program is to improve the health of male veterans. This is achieved by using volunteers to encourage them to understand their health and wellbeing and to work in partnership with professional providers in managing any identified issues.	Ex-serving ADF Members Family Ex-service Organisations
<b><i>Mental Health and Wellbeing After Military Service</i> information booklet</b>	2011	This booklet provides information and advice for veterans, other former serving personnel and their families. It contains information to assist in recognising early signs of difficulty, but is also intended for those not experiencing difficulties but who want to generally improve their mental health and wellbeing.	Ex-serving ADF Members Transitioning members Family
<b>Mental Health Support Brochure</b>	2014	Outlines the mental health treatment and support available through DVA and identifies how these services can be accessed.	Current Serving ADF Members Ex-serving ADF Members Family
<b>National Carer Support Service</b>	2009	Carer and Volunteer Support programs were initially established in the early 1990s as a mechanism to support carers of veterans, or veterans who are carers and to support volunteers working with the veteran community. In 2009 the service became nationally , through the development of information resources, capacity building, representation and relationship building. In 2012, the National Carer Support Service changed focus of main services from direct support to carers to support the community care service providers that deliver services to members of the veteran community.	Ex-serving ADF Members Family Ex-service Organisations

<b>On Track with the Right Mix</b>	2013	A self-help smart phone app to help serving and ex-serving personnel manage their alcohol consumption. Users can track the number and type of drinks consumed; the amount of money spent; and review the impact this has had on their wellbeing and fitness by showing the amount of exercise required to burn off the kilojoules consumed.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations
<b>Operation Life App</b>	2015	A mobile app designed to help those at risk deal with suicidal thoughts and is recommended to be used with the support of a clinician. The app provides on-the-go access to emergency and professional support and self-help tools to help regain control, keep calm and take action to stay safe. The app also contains web links to online resources, including information on suicide awareness, prevention training and counselling.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations
<b>Operation Life Online Website</b>	2013	Website to help ex-service community understand the warning signs of suicide. Provides information and resources to help keep calm and take action to stay safe, advice on how to offer help to someone else and stories from those touched by suicide. Information and support options are also available on the site if for those bereaved by suicide	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations



<b>Operation Life Workshops</b>	2007	<p>Operation <i>Life Workshops</i> are run Australia-wide by the Veteran and Veterans Families Counselling Service (VVCS). These workshops equip people with the skills and confidence to identify the signs of suicide, start the conversation about suicide, and link others into appropriate help. The workshops are available free to anyone in the ex-service community. The workshops consist of:</p> <ul style="list-style-type: none"> <li>• safeTALK – a half-day workshop that provides members of the community with information to recognise those who may be considering suicide and connect them with appropriate intervention services;</li> <li>• ASIST – a two-day, intensive workshop that equips participants with the skills to intervene when suicide is likely and reduce the immediate risk or secure additional resources for this purpose; and</li> <li>• ASIST Tune Up – a half-day ‘refresher’ workshop for people who have previously completed ASIST.</li> </ul>	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family  Ex-service Organisations</p>
<b>Peer to Peer Support Pilot</b>	2016	DVA has partnered with two consortiums, located in Sydney and Townsville, to conduct a 12 month pilot program to train ex-serving Australian Defence Force members as volunteer Peer Mentors to help their Peers suffering from a mental health condition.	<p>Ex-serving ADF Members  Ex-service Organisations</p>
<b>PTSD Coach App</b>	2013	A self-help app designed to help serving and ex-serving personnel understand and manage the symptoms that may occur following exposure to trauma. The app provides education about PTSD, information about self assessment and professional care, and tools to manage the stresses of daily life with PTSD.	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family  Ex-service Organisations</p>
<b>Stepping Out Program</b>	2008	The Stepping Out Program provides information and skills to manage the transition from the ADF to civilian life. It is a practical program that explores the concepts of major life changes, teaches skills for planning ahead and staying motivated and adaptable as well as setting expectations about what civilian life can look like.	<p>Ex-serving ADF Members  Transitioning members  Family</p>
<b>Support services for the children of veterans</b>	2016	Funding of \$2.1 million over two years for the Australian Kookaburra Kids Foundation to develop and evaluate a pilot program for the children of current and former serving members of the ADF affected by mental illness. The special program for children of	<p>Children of current serving and ex-serving ADF members</p>

<b>The Right Mix</b>	2001	The Alcohol Management Project was developed to create opportunities to reduce alcohol related harm in the ADF and veteran communities. <i>The Right Mix - Your Health and Alcohol</i> is the health promotion initiative that supports the message of achieving a right mix of low-risk drinking, a healthy diet and regular exercise. In September 2015, DVA relaunched the alcohol management website The Right Mix after it underwent improvements to make it more user-friendly and to reflect the latest research on alcohol consumption. The website has as its centrepiece a self-help program, using a range of interactive tools, including self-assessment, to identify motivational priorities and goals and peer supports. Personalised information automatically generates a self-help treatment plan. The website is mobile-enabled so users can access their plans on multiple platforms.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family Ex-service Organisations
<b>Trauma Recovery Programs - PTSD</b>	1994	DVA contracts mental health hospitals throughout Australia to provide evidence-based trauma recovery day programmes (TRP) – posttraumatic stress disorder (PTSD). Former members of the ADF who are DVA clients are eligible for the TRP. Current serving members of the ADF and first responders (such as police, ambulance officers or fire service personnel) may also access the programmes, where funded by their respective organisations. The TRPs are not intended to be stand-alone services, nor will they meet all the treatment needs of veterans. Rather, they aim to provide highly specialised, time-limited, evidence based treatment for PTSD and its common comorbidities.	Ex-serving ADF Members
<b>Veteran and Community Grants</b>	1999	DVA supports local community initiatives through Veteran and Community grants. These grants aim to maintain and improve the independence and quality of life of members of the veteran community by providing financial assistance for activities, services and projects that sustain and/or enhance wellbeing. These grants are available to eligible ex-service organisations that can demonstrate the ability to contribute to the welfare of members of the veteran community. In 1999, DVA consolidated the grant guidelines for a number of residential and community grants programs, into one set of guidelines - Veteran and Community Grants.	Ex-serving ADF Members Family Ex-service Organisations
<b>Veterans Employment Assistance Initiative (Vocational rehabilitation)</b>	2015	This initiative enhances the employment assistance and support currently provided under DVA's rehabilitation programmes. It aims to help injured former ADF members reclaim independence, realise their skills and capabilities, and achieve their vocational rehabilitation goals post-service in three main areas: enhanced vocational rehabilitation arrangements, employer engagement, and early engagement with clients through the ADF Rehabilitation Programme.	Eligible Ex-serving ADF Members

<b>Veterans Health Week</b>	1999	Veterans' Health Week provides an opportunity for veteran and ex-service community members and their families to participate, connect and influence the health and wellbeing of themselves and their friends. This is an annual event with changing themes that centre around health and wellbeing issues relevant to the veteran and ex-service community.	Ex-serving ADF Members Family Ex-service Organisations
<b>VVCS After Hours</b>	1994	Veterans Line is VVCS's after-hours counselling service. It is designed to assist veterans and their families who are coping with situations outside VVCS office hours. In 2009-10, the VVCS call back service commenced. This service provides, as part of its charter, support for VVCS clients at significant risk of suicide and self-harm through provision of systematic risk assessment, management and referral for after hours, weekends, and public holiday periods. The service allows coordinated management of high risk clients and aims to provide a seamless risk management response.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Family
<b>VVCS Case Management</b>	2009	VVCS was tasked to develop and implement a mental health case management service in 2008-09. The purpose of case management is to provide support for members of the veteran community with complex needs affecting their mental health and wellbeing. An 18-month project to develop and implement a clinical model of case management in VVCS was completed in November 2009. During the project, clinical staff were trained and assisted to identify and deliver a comprehensive case management service to clients with complex needs. In early 2010, the case management service was extended to the outreach program to enable regional and remote clients to benefit from coordinated management of community services in their locality.	Current Serving ADF Members Ex-serving ADF Members Family
<b>VVCS Counselling Services</b>	1982	The VVCS helps members of the veteran and ex-serving community, and members of their families, who are experiencing service-related mental health and wellbeing conditions. This service is free and confidential and offers a wide range of therapeutic options and programs for war- and service-related mental health conditions, including posttraumatic stress disorder, anxiety, depression, sleep disturbance and anger. VVCS also offers relationship and family counselling to address issues that can arise due to the unique nature of military service. All VVCS counsellors, whether centre-based counsellors, outreach providers or telephone line counsellors, have an understanding of military culture and work with clients to find effective solutions for improved mental health and wellbeing.	Current Serving ADF Members Ex-serving ADF Members Transitioning members Ex-service Organisations
<b>VVCS Crisis Assistance Program</b>	2002	The Crisis Assistance Program provides assistance to Vietnam veterans who are experiencing a family crisis. Veterans may be offered 'time out' in short-term emergency accommodation and are offered counselling or other strategies such as access to residential lifestyle and coping skills programmes conducted through the VVCS.	Vietnam Veterans

<b>VVCS Group Programs</b>		<p>VVCS offers group programs for common mental health issues and psycho-educational programs for couples, including a residential lifestyle program. The length of VVCS group programs varies from 2-day workshops to sessional programs, run over a number of weeks. All group programs are provided free to eligible participants. Group programs currently offered by VVCS are:</p> <ul style="list-style-type: none"> <li>• Beating the Blues</li> <li>• Building Better Relationships</li> <li>• Doing Anger Differently</li> <li>• F-111 Lifestyle Management Program (residential)</li> <li>• Lifestyle Management Program (residential)</li> <li>• Mastering Anxiety</li> <li>• Operation Life</li> <li>• Sleeping Better</li> <li>• Stepping Out (ADF transition)</li> </ul>	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family  Ex-service Organisations</p>
<b>VVCS Outreach Program</b>	1989	<p>VVCS outreach counsellors deliver services to clients who are unable to access a VVCS centre. At the end of June 2016, VVCS had a network of 1,101 outreach counsellors located throughout Australia. Outreach counsellors are qualified psychologists (83 per cent) and mental health accredited social workers (17 per cent), with an understanding of military culture and the veteran experience.</p>	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family</p>
<b>VVCS Website / Facebook</b>	2014	<p>These online tools provided VVCS with an opportunity to improve community mental health literacy, assist members with self-management and provide contact information and an additional referral pathway for those in need.</p>	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family  Ex-service Organisations</p>
<b>Wellbeing Toolbox</b>	2011	<p>The Wellbeing Toolbox was developed for DVA by Phoenix Australia as an early intervention, self-help website for serving and ex-serving ADF members and their families. It developed out of the Lifecycle Package of mental health initiatives. It aimed to assist in the management of sub-clinical mental health problems by providing learning modules which focus on coping strategies, resilience, goal setting and adjustment to civilian life following discharge from the military service. In 2015, DVA replaced the Wellbeing Toolbox with the High Res website, an enhanced, interactive resilience website incorporating elements of the Wellbeing Toolbox and Defence's SMART resilience program.</p>	<p>Current Serving ADF Members  Ex-serving ADF Members  Transitioning members  Family  Ex-service Organisations</p>

<b>YouTube Videos</b>	2012	'Don't suffer in silence' – 10 videos about the impact of mental ill health. The videos are aimed at reducing the stigma of mental health and encouraging help-seeking behaviours. The videos feature current service personnel, veterans and family members sharing their experiences in dealing with issues from depression, alcohol and substance abuse through to anxiety and loneliness. They all have the same and simple message: Help is available - Help can make a difference.	Current Serving ADF Members Ex-serving ADF Members Family
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## References

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- <sup>2</sup> Australian Institute of Health and Welfare 2016. Incidence of suicide among serving and ex-serving Australian Defence Force personnel 2001–2014. Cat. no. PHE 212. Canberra: AIHW. ISBN 978-1-76054-044-9 (PDF) Available online at:  
<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557671>
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<http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129557671>
- <sup>4</sup> World Health Organisation <http://www.who.int/topics/suicide/en/>
- <sup>5</sup> The Commission notes Defence is further refining its approach to implementing the Dunt ADF Review recommendations following the findings of an independent evaluation in 2014.
- <sup>6</sup> Advice provided to the Commission by the Australian Bureau of Statistics. Calculated as part of the Mental Health Services-Census Integrated Dataset, 2011 on the basis of 2011-12 and 2014-15 data from the National Health Survey.
- <sup>7</sup> Defence Annual Report 2015-16
- <sup>8</sup> Defence advised the Commission that examples of processes to ensure these qualities include mental health screening in recruiting for mental health conditions, suicide and self harm (and associated risk factors) and a lengthy medical and psychological interview, which screens for (amongst other things) mental health risk including suicide risk. Defence also noted that recruitment [screening aims to ensure that people at significantly increased risk are not recruited](#).
- <sup>9</sup> Directorate of People Intelligence & Research, Defence People Group, Department of Defence. (2016) ADF Families Survey: Absences and Relocations. DPIR PUB No 53/2016. Canberra: Australian Government.
- <sup>10</sup> National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC, p 67.
- <sup>11</sup> National Mental Health Commission, 2014: The National Review of Mental Health Programmes and Services. Sydney: NMHC
- <sup>12</sup> Available online at: <https://mhsc.aihw.gov.au/committees/mhssc/YES-survey/>
- <sup>13</sup> Department of Defence Supplementary Submission to the Senate Standing Committee on Foreign Affairs, Defence and Trade Inquiry into Suicide by Veterans and Ex-Service Personnel, February 2017. Available online at

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[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Senate/Foreign\\_Affairs\\_Defence\\_and\\_Trade/VeteranSuicide/Submissions](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/VeteranSuicide/Submissions)

<sup>14</sup> Administration of Rehabilitation Services Under the Military Compensation Act 2004, ANAO, 2016

<sup>15</sup> Administration of Rehabilitation Services Under the Military Compensation Act 2004, ANAO, 2016p. 32

<sup>16</sup> Administration of Rehabilitation Services Under the Military Compensation Act 2004, ANAO, 2016p. 10

<sup>17</sup> Directorate of People Intelligence & Research, Defence People Group, Department of Defence. (2016) ADF Families Survey: Absences and Relocations. DPIR PUB No 53/2016. Canberra: Australian Government.

<sup>18</sup> Muir, S., Hand, K and Weston, J. (2015) The role of the family in Australian Defence Force members' rehabilitation. The Australian Institute of Family Studies

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<sup>20</sup> Further information about the ESO community can be found in the ASPEN Foundation's 2015 *Ex-Service Organisations Mapping Project* report, available online at <https://www.aspenfoundation.org.au/esomp>

<sup>21</sup> Further information about the ESO community can be found in the ASPEN Foundation's 2015 *Ex-Service Organisations Mapping Project* report, available online at <https://www.aspenfoundation.org.au/esomp>

<sup>22</sup> Call to monitor veterans affairs charities, The Australian, 15 March 2017. Available online at: <http://www.theaustralian.com.au/national-affairs/defence/call-to-monitor-veterans-affairs-charities/news-story/f6a04f084546b060fc980b10a0bb6418>

<sup>23</sup> Australian Institute of Health and Welfare, Mental health services in Australia: Medicare-subsidised mental health-related services 2014-15. Available online at <https://mhsa.aihw.gov.au/services/medicare/>

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- <sup>34</sup> For further information and sources, please refer to the Literature Review.