INDEPENDENT STUDY INTO SUICIDE IN THE EX-SERVICE COMMUNITY

EXECUTIVE SUMMARY

initiated by the Minister for Veterans' Affairs,
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Full report at www.dva.gov.au

Executive Summary and Recommendations

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PART A Suicide and suicide programs in veterans

Section 2 Overview of suicide and suicide prevention

While there is evidence that military and similar institutionally-based 'gatekeeper programs' are effective (and may involve courses like ASIST in part), this is less true for community-based programs. While ASIST courses around the world have been evaluated many times, the evaluations are restricted to the levels of satisfaction and perceived utility by attendees and not their impact in reducing suicide or suicide attempts.

Systemic reviews of the research literature point to the value of other interventions such as clinician education including detection and treatment of depression and restricting access to lethal means.

Programs need to alert GPs and mental health professionals to the increased suicide risk among veterans, as well as their access to firearms. This is true particularly for rural clinicians as veterans living in rural areas are more vulnerable because of both their lack of access to mental health services and higher suicide rates in the general population. Can Do addresses some of these issues but could perhaps be developed further.

Strong evidence does not exist for veterans suicide prevention program aimed at risk factors known to be important in veterans, such as screening for at risk veterans who are depressed, living alone or following the break-up of a close relationship.

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

Suicide is recognised as a public health problem that can affect all sectors of society. Whilst suicide rates are lower in serving military groups than in the general population due to 'healthy worker' selection effects, this effect fades over time, so that some years after service, veterans of military service can have health problems that are worse than the general population.

The aim of this review is to examine suicide rates among the ex-service community both in Australia and overseas and to examine whether or not there are risk factors for suicide that are specific to suicide in this population upon which preventative strategies can be based. A literature search using key words related to veterans and suicide was conducted.

While Australian veterans have not been studied as extensively as overseas veterans the studies that have been undertaken have shown some evidence to indicate elevated suicide rates among Australian veterans compared to the general population. The evidence is however by no means conclusive. Whilst US based studies mostly

indicate elevated suicide rates among veterans, the data from other countries is also not conclusive.

Risk factors for suicide among veterans can be classified into the following categories: socio-demographic factors; psychiatric and psychological factors; access to and availability of means of suicide and exposure to combat.

Thus the research to date remains largely inconclusive as to whether or not veterans are at greater risk of suicide than the general population, and if they are at increased risk what risk factors are specific to this population.

The review found some evidence to suggest that veterans may be at increased risk of health problems which could lead to elevated mortality, when compared to community norms, such as physical health problems and psychological disorders. In addition, whilst many of the risk factors are similar to those among the general population, such as living alone and the break-up of a close relationship, some such as availability of firearms and exposure to combat are specific to veterans and may form the basis of preventive activity.

Section 4 Rapid literature review of suicide prevention programs

While the evidence-base for the relative effectiveness of suicide prevention approaches is not extensive, there are sufficient numbers of recurrent themes to envisage the key features of a successful intervention relevant to programs for veterans. These are first, embedding the suicide prevention program within a broad-based community education, treatment and support service that minimises stigmatisation. Second, the delivery of some of the following core program components should be present. These are gatekeeper and clinician training, early detection and screening protocols, immediate risk reduction (access to lethal means, exposure to stressors, use of alcohol and drugs, peer or buddy watch systems and appropriate medication regimes.

PART B - Services for Australian Veterans with mental health problems

Section 5 Transition from the ADF

A seamless discharge is important for all ADF members, transitioning-out for medical reasons. A number of services for which either the ADF or DVA have responsibility, have now been established to support this. Services should start as soon as possible after first notification of intention to discharge and should continue for a period well beyond discharge. Joint auspice of these services by ADF and DVA is highly desirable. It is important that these services provide information to members on the full range of services and benefits available to them so they can pursue ones most relevant to them. Members transitioning-out of the ADF with chronic mental health conditions have special needs beyond comprehensive provision of information. The Townsville Lifecycle Transition Mental Health and Family initiative adds value here but an additional case management dimension may be necessary.

It is important that members of the ADF who transition out for reasons of mental illness believe that their contribution to the ADF is fully acknowledged. Joining the

ADF requires the new member to undertake a necessary major, somewhat forcible psychic reorientation. Failure then to succeed in the ADF for whatever reason sets in train a sequence of possible negative reactions – anger and resentment against the ADF, failure to find new employment, illness and invalidism. This may occur for a variety of reasons - health, aptitude, unsuitability, guilt, shame, bullying and post-deployment reinterpretation of the ADF experience. This reaction is most undesirable in both personal and economic terms for the individual, ADF and community

Section 6 Veteran compensation schemes and mental health

It is widely recognised that the three military compensation schemes - Veterans' Entitlement Act (VEA), Safety Rehabilitation and Compensation Act (SRCA) and Military Rehabilitation and Compensation Act (MRCA) - are difficult for veterans to navigate and DVA delegates to advise and process. They also have differing aims - VEA is essentially a military compensation scheme, SRCA a worker's compensation scheme oriented to rehabilitation and MRCA has features of both. The operation of MRCA and veterans' compensation more generally will be reviewed in 2009. It would simplify the scheme considerably if the three acts could be rolled-up into one successor Act. It is worth noting that Canada and US have one scheme only and the UK one past and present scheme operating.

Some of the complexity of operating the three different military compensation schemes is administrative in nature with multiple forms for veterans to complete and multiple medical consultations for them to attend. The Inter Departmental Working Group within Defence Links has been seeking administrative simplification of the three Acts. Two outcomes of this have been the Single Claim Form for all three compensation schemes and the Separation Health Examination for members transitioning out of ADF on medical grounds currently being trialed.

The Client Liaison Unit which operates across all three Acts, though without delegate powers appears very successful. The High Needs Case Management Pilot established initially to process MRCA claims in Sydney, and with delegate powers, also proved successful but has not been continued. To succeed it, the changing business processes of the national Military Rehabilitation and Compensation Group (MRCG) group includes a more needs-based and client-centred approach to veteran's compensation claims which may involve case management for some clients. It should extend though to cover compensation claims under all three Acts, particularly the VEA.

Veterans submitting mental health-related claims, whether primary or on appeal, may face difficulties and react negatively to delays and setbacks. In the worst possible case this may manifest itself in self-harm. A separate process for considering their claims would seem prudent.

A significant proportion of primary claims for compensation, that are not accepted by DVA go to review or appeal and are overturned after considerable delay. The reason for this is that more complete information is submitted at review than at the initial submission. New administrative processes could speed up favourable outcomes for some veterans.

There were many reports of frustration and anguish among veterans and their families in dealing with the DVA. These are probably inevitable during the period when the claim has not been decided or the outcome did not turn-out as anticipated. Nevertheless, long delays in processing some claims and accompanied by little communication with some claimants still occur. It was reported that while some DVA delegates are excellent communicators, others are less so.

A strong orientation to client service is now a feature of all modern public and private human service organisations. Veterans who have represented their country at war can expect respect and empathy.

The Veterans Review Board works well with independent and eminent members, many nominated by ESOs. However very few VRB members have mental health, counseling or even medical backgrounds. While it is important to have VRB members with legal backgrounds to interpret the law, it is just as important to have members with medical and mental health backgrounds to interpret the medicine and mental health science.

Section 7 PTSD and compensation

A number of people believe that many veterans making applications for PTSD are unduly influenced by consideration of generous compensation pension and benefits. It is a fact that in Australia, DVA TPI disability rates for PTSD are high. These view are expressed not only in Australia but other countries as well. Their significance is that they have the potential to influence both clinicians and others in decision-making. They have also sparked a very lively research debate. Dohrenwend et al (2006) sum up best. They conducted a very careful study of the National Vietnam Veterans Readjustment Study (NVVRS) in the US. They found little evidence of falsification, an even stronger dose-response relationship between exposure to traumatic stress and PTSD, and psychological costs that were lower than previously estimated, but still substantial. Nevertheless, more research is needed.

PTSD has distinctive symptoms which should make its diagnosis relatively straightforward form other mental illnesses. The SoPs are important in establishing whether prior events are associated with the development of disease, in this case PTSD. In themselves they can not though directly attribute its connection to service. DVA has therefore been in the practice of consulting historical military record sources to confirm whether or not there is documentary evidence of exposure to Category 1 Stressors in a military setting that the veteran nominates as responsible for their PTSD.

There are however a number of caveats to consulting historical military record sources for these purposes. First, linking these to Statement of Principles can not occur in a mechanistic fashion as the SoPs do not cover very unusual instances of service connections. Second, historical records are not perfect. Third, some veterans' reports of combat exposure change over time as a function of PTSD symptom severity but more normally, as stories are told and retold over decades. The production of documentary evidence in a tribunal or elsewhere disproving the veteran's claim is very confronting.

The use of historical military record sources would seem more legitimate in cases of suspected fraud to investigate the veracity of a claimed exposure to a nominated traumatic stress event. These are still problematic if they follow an anonymous 'tipoff' particularly when made by an anonymous informant network with unclear motivations. While tipoffs need investigating under law, there needs to be some substantiation to ensure that the information provided is not capricious or malicious. A formal investigation for fraud is very confronting to the veteran and, in the worst possible case can manifest itself in self-harm.

The adoption of the Statement of Principles is a major step towards establishing whether a factor can be considered causal for a disease and this applies to PTSD. Establishing whether this factor is connected to the veteran's service is less advanced for PTSD and studies to identify better processes to establish this would be timely. In the meantime, it would be better to generally avoid the use of historical investigation of military sources in non-fraud cases.

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

The ESOs have made an important contribution to the development of services for veterans. Through their Welfare and Pension Officers they have also been able to give assistance to veterans making claims for service-related compensation. Considering that these officers are volunteers they make very commendable contributions. The TIP and BEST programs have also made a significant contribution in providing training, some salary and other support to Officers.

Volunteer Welfare and Pension Officers are ageing and they are not being replaced by younger volunteers. This is because membership in ESOs is much less common in younger veterans who have participated in the post-Vietnam conflicts and peacekeeping activities. In addition, the Officers who themselves may be TPI pensioners will have most experience with VEA. While they will have received training to familiarise them with MRCA and SRCA, this may be insufficient. Appearing as an advocate at VRB and AAT hearings requires aptitude and skill and is a large responsibility.

It is now time, recognising again the contribution of the volunteer officers to move to a new system. In designing a new system in the Australian context, it will be most appropriate that ESOs are involved, officers operate increasingly on a paid basis, training is of a higher standard (TAFE Certificate 4 or Diploma) and DVA will need to be involved in funding. The new system will need to take into account that younger veterans are much less frequently becoming members of ESOs. A form of quality assurance is required to provide added confidence that the system was working well. Finally, it is important that in moving to this much more paid system of support and representation, that there is still a role for the existing volunteer Pension officers.

Section 9 Mental health programs and services for veterans

Since the release of its Mental Health Policy and Strategic Directions paper '*Towards Better Mental Health for the Veteran Community* in 2001, DVA has become increasingly active in putting in place community mental health promotion programs. This has gone alongside increasing level of support for the education of health

professionals involved in treating veterans with mental health problems. This compares favourably with other countries similar to Australia.

It is some time though since the release of the Mental Health Policy and Strategic Directions paper in 2001 and the Consultation in 2004. ACPMH, on contract with DVA is conducting an evaluation of DVA's Mental Health Initiatives for 2007-10. It would be expected that a new mental health strategy would follow this evaluation.

VVCS has made a major contribution to the delivery of counselling services to veterans and very importantly for their families. The new mental health initiatives of the Australian Government are making possible a new horizon for community access to (subsidised) private counseling services of both psychologists and also social workers. These now impact on VVCS.

Support through subsidy, however is only provided for the delivery of evidence-based treatments. In addition there are restrictions such that services can only be subsidised it they are appropriate to the level of training of practitioners (including GP) providing the service. Thus, registered psychologists (and GPs) are able to deliver *Focused Psychological Strategies.* They are not able to provide *Psychological Therapy* which can only be delivered by clinical psychologists ie members of the Australian Psychological Society (APS) College of Clinical Psychologists.

It is important therefore that VVCS registered psychologists restrict themselves to *Focused Psychological Strategies* and only clinical psychologists engage in *Psychological Therapy.* VVCS clients should also be confident that if a DSM-IV mental condition is present it will be diagnosed treated. This may require prescription of psychotropic drugs and therefore medical involvement. There should therefore be some level of involvement of psychiatrists or GPs with interests in mental health who can prescribe such drugs in all VVCS centres.

Barriers to care are widespread in veterans who have had mental health problems either during or after service. These barriers among others consisted of veterans' perceptions of their own predicament and use of self-management approaches which was preferred to the perceived 'uselessness' of available treatments. The Lifecycle project targeting 'hard to engage' ex-service members is addressing this issue. The proposed Keeping in Touch program constitutes one option for an Outreach program to this hard-to-engage group of veterans. It could be a vehicle to promote a variety of mental health and wellness programs and events to veterans and their partners.

While there is marked variation in the level of DVA disability pensions for veterans in different theatres of war, there is little doubt that levels of PTSD are elevated in Australian veterans. It is probable though that the majority of Australian veterans with PTSD are not getting best practice (evidence-based) treatment for early onset cases. One well-informed estimate is that only around 30% are receiving such treatment. Patients with late-stage PTSD are disadvantaged by the late stage of their presentation. It is not clear how effective treatments are for these late-stage presentations - or how suitable they are for Younger veterans.

Mental health problems may not only impact on veterans but also their families. The finding that children of Vietnam veterans have three times the expected rate for

suicide than children of other members of the population is the most striking example of this impact. It is important therefore that families receive needed services for themselves. Families should also be involved in relevant events and services (treatment or other) where this is possible.

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.