The Royal Australian & New Zealand College of Psychiatrists

Your Health in Mind

Submission to the Royal Commission into Defence and Veteran Suicide

September 2022

Improving the mental health of communities

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Royal Australian and New Zealand College of Psychiatrists submission

Royal Commission into Defence and Veteran Suicide

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About the Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) is a membership organisation that prepares doctors to be medical specialists in the field of psychiatry, supports and enhances clinical practice, advocates for people affected by mental illness, and advises governments on mental healthcare.

The RANZCP is the peak body representing psychiatrists in Australia and New Zealand and as a bi-national college, has strong ties with associations in the Asia-Pacific region. The RANZCP has more than 7700 members including more than 5500 qualified psychiatrists and over 2100 members who are training to qualify as psychiatrists. Psychiatrists are clinical leaders in the provision of mental healthcare in the community and use a range of evidence informed treatments to support a person in their journey of recovery.

The feedback contained within this response is based on extensive consultation with several RANZCP Committees and members, most prominently the Military, Veterans' and Emergency Services Personnel Mental Health Network (MVESPMHN) Committee. RANZCP Committees include psychiatrists with experience working within the fields of occupational health and trauma research. As such, the RANZCP is well positioned to provide assistance and advice due to the breadth of academic, clinical and service delivery expertise it represents.

The RANZCP has welcomed the opportunity to provide information to the Royal Commission into Defence and Veteran Suicide (Royal Commission) with the issue of defence and veteran suicide being of high interest. The RANZCP would welcome the opportunity to provide further contributions.

Introduction

The Royal Commission has heard many important stories of defence and veteran suicide. The RANZCP acknowledges all serving members and veterans and their families who have been affected by suicide. We are committed to advocating for and contributing to improved systems to address the mental health and wellbeing needs of both veterans and currently serving members of the Australian Defence Force (ADF), who are referred to as serving members in this submission.

The Royal Commission and the multitude of other Government inquiries related to serving member and veteran mental health have arisen out of an unmet need for access to holistic, effective care. The RANZCP emphasises that improved access to psychiatric care for serving members and veterans is a pivotal outcome for the Royal Commission. Completed suicide is related to mental disorder in up to 90% of cases where a psychological autopsy is conducted.[1, 2]

The Australian Institute of Health and Welfare (AIHW) final report to the *Independent Review of Past Defence and Veteran Suicides* (the AIHW report) indicated lower rates of mental disorders, stating that 75% of male ADF members who died by suicide in the specified cohort had at least one mental and behavioural disorder.[3] The AIHW report does not state that psychological autopsies were conducted, or account for those who went undiagnosed/untreated. Conducting a psychological autopsy is considered a rigorous method of determining the presence of a mental disorder, as it is well known that many people do not receive a diagnosis or treatment.[4-6] Therefore, the RANZCP recommends that the Royal Commission consider prevalence statistics which have included psychological autopsy within the methodology, as provided in our reference list.

Without addressing the prevalence of mental disorders and ensuring access to psychiatric diagnosis and treatment, suicide prevention efforts will be hindered. The literature highlights that the treatment of mental disorders is critical to suicide prevention.[7] The adequacy of psychiatric care provided to serving members and veterans must be a core focus of investigation for the Royal Commission.

The role of psychiatry

In suicide prevention

As a result of their training and experience, psychiatrists have comprehensive clinical knowledge that can inform current approaches to suicide prevention. Psychiatrists are mental health specialists who understand suicide and its potential causes and triggers. Psychiatrists are committed to providing and promoting high quality mental healthcare in the community, and can support people who are experiencing psychological distress, with or without a mental disorder.

The RANZCP is committed to embedding suicide prevention approaches in the psychiatry training curriculum, to ensure that psychiatrists provide appropriate, effective and evidence informed treatment and practice to support people in distress. Psychiatrists have a critical role in identifying and treating any underlying mental disorder.

As a member of Suicide Prevention Australia, the RANZCP is committed to supporting people in suicidal distress and working with governments and communities to prevent suicides. This was illustrated by RANZCP engagement with the House of Representatives Select Committee Inquiry into Mental Health and Suicide Prevention. The RANZCP provided a submission and attended a hearing, as demonstrated in the *Final Report*.[8]

Utilising the psychiatry expertise within the RANZCP President's Advisory Group on Suicide, the RANZCP has published:

- Position Statement 101: Suicide prevention – the role of psychiatry.
- Executive Summary: Suicide Prevention and COVID-19.
- Clinical Practice Guideline for the management of deliberate self-harm.
- Suite of three 'coping with a patient suicide' resources:
  1. For those in psychiatry training: Coping with a patient suicide.
  2. Psychiatry supervisors: Supporting those in psychiatry training after the suicide of a patient.
  3. Health services: Supporting team members after the suicide of a patient.

In supporting the mental health of veterans

The RANZCP Military, Veterans' and Emergency Services Personnel Mental Health Network (MVESPMHN) promotes wider interest and expertise amongst psychiatrists and those in psychiatry training, in the mental health of military veterans, serving armed forces members, and serving and ex-serving emergency services personnel (paid and voluntary). The MVESPMHN currently consists of over 400 members.

The RANZCP comprises of experts in trauma and has:

- Endorsed Phoenix *Australia's Guidelines for the Treatment of Acute Stress Disorder, PTSD and Complex PTSD.[9]*
- Published a 'Your Health In Mind' article on PTSD.
- Published Position Statement 99: The mental health of veterans and defence force service members.

In informing the Royal Commission

Psychiatrists have direct experience of value to the Royal Commission. Many have provided evidence in hearings. In addition to the specialised expertise in military mental health and suicide prevention, psychiatrists are leaders of mental health multidisciplinary teams with involvement in coronial inquests and working within Mental Health Acts. These are experiences that cannot be gained in other domains.

Summary of recommendations

The RANZCP has organised its' recommendations for action into five pillars of change required to reduce veteran and serving member suicides.

Pillar one: Mental disorders are addressed

- Register all members joining the ADF with the Department of Veterans' Affairs automatically.
- Address mental disorders to prevent suicidality in serving members and veterans.
- Fund research to find more effective treatments for common veteran mental health conditions such as posttraumatic stress disorder and major depressive disorder.
- Routinely assess those experiencing chronic pain and/or insomnia for suicidality.
- Address the prevalence of veteran homelessness.
- Systematically include lifetime trauma exposures in the assessment of suicide risk in ADF personnel in conjunction with other risk factors including current levels of psychological distress.
- Establish customised e-therapy programmes for sub-syndromal PTSD, depression, and anxiety.
- Evaluate the ADF culture regarding help seeking and mental health via an external review.
- Promote the availability of existing mental healthcare services provided by Open Arms and the level of confidentiality available.
- Expand peer worker initiatives and visibility of lived experience of a mental health condition in the military and for veterans.

Pillar two: Improved access to mental health services

- Meet demand for psychiatry services by increasing the psychiatry workforce.
- Increase access to psychiatry services by attracting psychiatrists:
    - By reducing administrative burdens for psychiatrists.
    - By consulting the RANZCP on amending the fee schedules which impact psychiatrists.
- Expand the number of uniformed psychiatrists, psychiatry trainees, and clinical psychologists in the ADF.
- Improve specialisation, education and training of the health workforce in defence and veteran care:
    - Via funding to develop Veteran Centres of Excellence and consultation services for veterans with severe, complex disorders.
    - Via further funding for the Military and Veteran Psychiatry Training Program.
    - Via trauma-informed care and military and veteran training for the wider workforce.
    - Via expansion, organisation and standardisation of registrar and psychiatrist training in the mental healthcare of military personnel and veterans.

Pillar three: A lifetime wellbeing approach

- Provide a tailored continuum of care for serving members and veterans which has a focus on lifetime wellbeing.
- Consider families and carers in support systems and plans.
- Fund research to gauge periods and cohorts that are at a high risk of suicide.
- Provide a gold card to any veteran, or limit this to veterans who were deployed during service.
- Ensure the number of complex case managers meets demand.
- Consider the lifespan of a serving member when developing and reforming support systems for serving members and veterans.
- Provide access to intensive transition services, tailored to different forms of discharge and transition.
- Improve communication with treating teams for holistic care.
- Improve processes for rehabilitating psychologically injured soldiers within the workplace.

Pillar four: Integrated systems of governance

- Strengthen and consolidate governance mechanisms to promote accountability
- Introduce an effective mental health and suicide prevention strategy for serving members and veterans
- Adapt legislative frameworks:
    - To reduce legislative complexity.
    - To reframe the purpose of the legislative framework.

Pillar five: A growing evidence base that is utilised effectively

- Invest in the collection of further data for system improvement.
- Develop a more strategic approach to research.
- Nurture experts in the field of serving member and veteran mental health.
- Establish better processes for consistent data collection and evaluating services.
- Develop a strategy to improve PTSD treatment outcomes.
- Utilise the existing evidence on military and veteran mental health.
- Utilise the existing expertise in military and veteran mental health, trauma, and suicide prevention.

Pillar one: Mental disorders are addressed

The RANZCP's recommendations for action contained within pillar one relate to the Royal Commission Terms of Reference matters:

> *"a. systemic issues and any common themes among defence and veteran deaths by suicide, or defence members and veterans who have other lived experience of suicide behaviour or risk factors (including attempted or contemplated suicide, feelings of suicide or poor mental health outcomes);*
>
> *b. a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues, such as the following:*
>
> *…i.v. the availability, accessibility, timeliness and quality of health, wellbeing and support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services".*

Prevalence

Prevalence of suicidality in serving members and veterans

Action: Register all members joining the ADF with the Department of Veterans' Affairs automatically.

The RANZCP highlights that serving members and veterans are a priority group for suicide prevention efforts. From 2001 to 2018, there were 465 confirmed suicides in veterans, serving members and reserves.[10] Veterans comprised of 57% of these deaths.[10] Data on serving member and veteran suicidal ideation, plans and attempts is minimal; the data that does exist indicates that there are higher rates of suicidality[a] in veterans than there is for serving members or civilians.[10, 11]

- *Serving members*

Between July 2019 and June 2021, approximately 1,439 serving members presented to the clinics for suicidal ideation with 84 presentations for suicidal behaviours[b].[12] While serving members are less likely to die by suicide than civilians, there appears to be higher levels of suicidal ideation and suicide plans among serving members than civilians.[2] A 2010 study indicated that 4% of serving members had self-reported suicidality in the year prior.[10] Further, serving members were at a much higher likelihood of presenting with suicidal behaviours when they experienced certain kinds of trauma.

- *Veterans*

Evidence indicates that the suicide rate of male veterans in Australia is 14% higher than age-matched civilians, and more than twice that of full-time serving members or reserves.[10] Among female veterans, evidence indicates the suicide risk is 115% higher than female civilians.[10] When comparing younger veterans to civilians of a similar age; those who had left the service aged under 30 had a suicide rate 2.2 times that of Australian men the same age.[10, 13] These statistics are similar in Canada and the United States.[14, 15]

Regarding service access, 53% of male veterans who died by suicide between 2014 and 2018 had accessed mental health services in the year before their death, in comparison to 38% of male civilians who died by suicide in this period.[3] The RANZCP highlights that there are eligible Department of Veterans' Affairs (DVA) clients who do not use veterans' services, indicating barriers to care. The AIHW report found that 66% of serving members and veterans who died by suicide were not accessing DVA services.[3] DVA registration allows members to obtain their DVA White Card, which enables entitlement to paid mental healthcare. By automating what currently acts as a bureaucratic barrier, access and affordability of psychiatric treatment for veterans is increased. This could be prioritised in the Defence and DVA future joint

[a] Refers to suicidal ideation, in addition to suicidal behaviours and suicide plans.
[b] Refers specifically to behaviours rather than ideation, including deliberate self-harm and suicide attempts.

metal health strategy mentioned in the DVA *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023*.[16]

Prevalence of mental disorders in those who die by suicide

Action: Address mental disorders to prevent suicidality in serving members and veterans.

The RANZCP highlights that serving members and veterans must receive appropriate diagnosis and treatment for any mental disorders that are present. The literature highlights that the treatment of mental disorders is critical to suicide prevention.[7] The presence of a mental disorder is a high risk factor for suicidal behaviour.[17, 18] Completed suicide is related to mental disorders in about 90% of cases where psychological autopsies are conducted.[1, 2, 17] Without addressing the prevalence of mental disorders and ensuring access to diagnosis and effective treatment, suicide prevention efforts will be hindered.

Evidence on the presence of a mental disorder in people who complete suicide is not consistent, as a psychological autopsy is not always conducted. This may result in the underrepresentation of presence of a mental disorder.[6] The RANZCP recommends that the Royal Commission consider prevalence statistics which have included psychological autopsy within the methodology.

The RANZCP finds that conducting a psychological autopsy is an effective method of understanding risk factors that were present (such as the presence of a mental disorder) as it is well known that many people do not receive a diagnosis or treatment.[4, 5, 19] Most people with suicidal behaviours are not treated.[19] It has been found that 47% of male veterans who died by suicide between 2014 and 2018 were not recorded as having accessed mental health services in the year before their death, in comparison to 62% of male civilians who died by suicide in this period.[3] For more information on the role of psychiatry in suicide prevention, please see RANZCP Position Statement 101: Suicide prevention – the role of psychiatry.

Prevalence of mental disorders in serving members and veterans

Action: Fund research to find more effective treatments for common veteran mental health conditions such as posttraumatic stress disorder and major depressive disorder.

As a consequence of access to ancillary health services, selection processes, the structure, routine, brotherhood and purpose provided by military employment, and access to ancillary health services, serving members are normally expected to be significantly healthier than the general population. However, an estimated 46% of formerly serving members who transitioned out of service between 2013 and 2018 had met the diagnostic criteria for a mood disorder in the 12 months preceding their transition.[20] This is more than double the 12 month prevalence of a mood disorder found in the Australian population.[21] The most common type of disorder in the recently transitioned ADF cohort was anxiety disorders[c] (37%), followed by affective disorders[d] (23.1%) and alcohol use disorders (12.9%).[20] In this study, 55.2% of those diagnosed with any type of mental disorder was also diagnosed with one or more comorbid mental disorders.[20] The RANZCP notes that there are risk factors specific to the military which provide context to these statistics.

RANZCP members report that major depressive disorder (MDD) and posttraumatic stress disorder (PTSD) are among the most common conditions associated with serving members and veterans. For most patients, MDD is a relapsing and remitting condition, with a significant percentage of people experiencing long term symptoms.[22] PTSD is often a chronic condition, with some longitudinal studies finding a high likelihood of recurrent symptoms, and military combat exposure as a significant risk factor for chronic PTSD.[23] The

[c] PTSD was the most common form of anxiety disorder found.
[d] Depressive episodes were the most common form of affective disorder found.

RANZCP highlights the limitations of available, evidence informed treatments for these conditions, with research to find more effective treatments needed.

Risk and protective factors

Risk and protective factors for suicide

Action: Routinely assess those experiencing chronic pain and/or insomnia for suicidality.

The RANZCP highlights that research finds protective factors against suicidal behaviours may include:

- Treatment of mental disorders that are present.[1]
- Appropriate cognitive, behavioural, and pharmacological therapies.[19, 24]
- Family and community attachments and support.[4] Studies consistently find that social isolation is a high risk factor for suicide.[1, 19]

Several risk factors for suicide have also been identified.[19, 25] The presence of a mental disorder is one of the strongest predictors of suicide.[18] An individual's vulnerability to suicide arises from a confluence of individual and socio-economic factors, including genetic, psychological, social and cultural, and adverse life events such as loss, trauma and interpersonal conflict. With many theories and frameworks of risk factors proposed, no single theory or framework can entirely identify the causes of suicidality.[25] In this submission, the RANZCP focuses primarily on psychiatric risk factors for suicide for the reasons outlined in the section prevalence of mental disorders in those who die by suicide.

The RANZCP affirms the importance of socio-economic risk factors and proximal life events which often co-occur and exacerbate risk.[4] The most commonly reported socio-economic risk factors associated with suicide include: disruption of family by separation or divorce, relationship problems with a spouse or partner, disappearance or death of a family member, legal problems, economic problems, and limitations due to disability or chronic health condition.[26] There are also higher rates of suicide among certain occupational groups, such as those with access to lethal means.[27]

Emerging research shows that suicidal thoughts are more likely to progress to a suicide attempt when there has been childhood trauma, a culturally and linguistically diverse (CALD) background, lower educational achievement, earlier onset of a mood disorder, comorbid lifetime substance use disorder (SUD), less sense of control in their lives, and poor social support.[28] Symptoms of mental disorders can have significant impacts on social support and family relationships, demonstrating how risk factors can culminate and coincide.

The RANZCP emphasises that chronic physical pain, especially in the elderly, is associated with increased suicide risk. The 2021 Census found that 60% of previous service members have a long-term health condition, demonstrating the health challenges for this cohort.[29] Feelings of helplessness and hopelessness about physical pain, and the desire to escape from pain contribute to suicidality in people with chronic pain.[30] Similarly, insomnia elevates risk of suicide.[31] The management of pain and insomnia, typical comorbid symptoms in a veteran presentation, should be prioritised in people experiencing negative moods and/or suicidal thoughts or behaviours. Those experiencing chronic pain and/or insomnia should be routinely assessed for suicidal ideation.

The RANZCP is concerned that suicidal ideation can progress to suicide plans, attempts. and completion.[17] One study found that 60% of these progressions occur within one year from the initial experience of suicidal ideation.[17] A variety of mental disorders increase the risk of experiencing suicidal ideation.[18] Mental disorders with symptoms of anxiety and low impulse control provided some predictive value for the potential to act on this ideation.[18] Self-harm is considered to be a risk factor for suicide attempts.[32]

Risk factors specific to the military

The RANZCP highlight that many of the aforementioned suicide risk factors are exacerbated in the military, or are an inherent facet of military service, such as access to means of suicide. Serving members still face significant, and often unique risks to mental health, including stigma and exposure to trauma.[20] The risk factor of disruption or separation of family and loved ones is part of deployment, which can be prolonged. For many, this was worsened by the pandemic where deployed serving members were unable to visit family and loved ones. Injuries which cause physical and chronic physical pain or health condition, and disability, are more likely to occur in a military role than in most industries.

Action: Address the prevalence of veteran homelessness.

The RANZCP is concerned about the prevalence of veteran homelessness. Suicide and suicidality is more prevalent in people experiencing homelessness than those who are not.[33, 34] United States research has long shown that veterans are at a high risk of homelessness (2-3 times the risk of non-veterans).[35] More recently, it has been found that veterans are overrepresented in the homeless population of Australia.[35] It is estimated that over a 12 month period there were 5,800 veterans in Australia who were homeless.[35] One study found that 5.6% of people sleeping rough in Australia were veterans, with veterans more likely to spend longer periods of time sleeping rough, and more likely to report health and social issues than non-veterans.[36]

Homeless veterans in Australia are at a higher risk of experiencing psychological distress and are at significantly higher risk of suicidality.[33] Evidence suggests that veteran suicidality increases in the period prior to homelessness.[33] This indicates that assessments of veterans must consider housing stability to prevent homelessness and associated distress.[33] The risk factors for veteran homelessness are similar to those for suicide, e.g., the presence of mental disorders, including SUDs.[33, 35, 37]

Due to the connection between homelessness and suicidality, government efforts in the United States to prevent veteran suicides have focussed on ending veteran homelessness.[37] A variety of intensive, outreach, and community mental health services are required to support veterans experiencing homelessness.[37] Such services must coordinate with housing support and addiction services to provide more effective treatment with the aim of preventing suicides.[37] The RANZCP highlights that a Housing First approach is increasingly considered an effective approach to homelessness.[38] Investigation is required to determine if DVA mental health services and case management services have the capacity to engage the estimated numbers of veterans experiencing homelessness and connect them with housing support services.

Trauma

Action: Systematically include lifetime trauma exposures in the assessment of suicide risk in ADF personnel in conjunction with other risk factors including current levels of psychological distress.

It is known that exposure to trauma occurs in the ADF. This is to be expected, as entering dangerous areas is a function of the ADF. Serving members and veterans can present with complex symptoms and mental disorders characterised by the extended, repetitive and intensive nature of cumulative trauma, a combination of mortal threats, traumatic losses and morally compromising experiences.[39-42] PTSD occurs in high rates among veterans and there is evidence that PTSD is linked to suicide risk.[43, 44] There is high rates of co-occurring disorders such as SUDs and MDD.[44]

There is also evidence to suggest an increased likelihood of suicidality is linked to increased levels of exposure to military combat.[44] While experiences such as witnessing atrocities or accidentally injuring or killing another person may pose the most significant risk, it is important to acknowledge the wide range of

mental health risks affecting current and former serving members. This includes bullying, harassment, and sexual trauma, and the difficulties caused by recurrent relocations and displacement from the family unit.[2, 45-47] The RANZCP highlights that these mental health risks are also significant risk factors for suicidality.

The RANZCP emphasises the role of such traumatic events in mental disorders such as PTSD and suicidality, particularly in relation to those who have been deployed.[10, 44, 47] The risks associated with traumatic experiences do not diminish following discharge from military service, with strong evidence to support the continuing effect of such traumatic stressors on an individual's mental health.[48] Evidence has found that serving members are at a much higher likelihood of presenting with suicidal behaviours when they had experienced traumas such as direct combat, torture, or rape, and that this likelihood increases when numbers of traumatic experiences compound.[10, 47]

As such, the traumatic experiences of military service present a risk factor to individuals not merely during the time of their service but potentially for the rest of their lives. For this reason, lifetime trauma exposures must be systematically included in the assessment of suicide risk in ADF personnel, in conjunction with other risk factors including current levels of psychological distress. For patients with PTSD, it is recommended that suicide risk is regularly assessed.[44] Evidence has also found a link between trauma and risk of homelessness.[35]

The RANZCP also highlights that the connection between trauma and suicidality is of great relevance in planning transitions and access to treatment after leaving the service. The RANZCP has endorsed the 2020 Phoenix *Australia Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, PTSD and Complex PTSD*, and was involved in their development.[9] These Guidelines provide high quality recommendations for responding to trauma and related conditions, containing a chapter on military and ex-military personnel as a specific population and trauma type.

Action: Establish customised e-therapy programmes for sub-syndromal PTSD, depression, and anxiety.

High levels of PTSD symptoms and mental disorders are found in veterans returning from deployment, who are screened.[44, 47] The RANZCP recommends that customised e-therapy programmes are established for sub-syndromal PTSD, depression and anxiety. It is also worth noting that significant PTSD symptoms may be experienced without receiving a formal diagnosis for PTSD.[43] Programs could be undertaken anonymously by serving members, and be effective in overcoming barriers to care and socialising members to therapy. For more information, please see RANZCP Position Statement 98: Benefits of e-mental health treatments and interventions.

Barriers to help-seeking

The RANZCP highlights the need to address barriers of access to psychiatry services and mental health supports for serving members and veterans throughout the lifespan. A focus on outreach, engagement, and addressing barriers to healthcare access may result in reduced suicidality.[49] A key barrier to help-seeking is low access to psychiatrists, which is addressed in Pillar two.

Military culture

Action: Evaluate the ADF culture regarding help seeking and mental health via an external review.

The RANZCP understands that military culture may act as either a barrier to help-seeking or a protective factor through good leadership and unit cohesion.[20, 50] In an unsupportive workplace culture, for example if bullying, harassment and unacceptable behaviours such as initiation ceremonies are present, military culture is likely to be a barrier to help-seeking.[47] Ongoing review and reform of military culture is

required as part of the suicide prevention response in the military. While efforts have been made in this realm, there is room for improvement. The Australian National Audit Office (ANAO) audit of Defence's implementation of *Pathway to Change: Evolving Defence Culture 2017-2022*, found that Defence was 'unable to provide assurance of the effectiveness of its implementation to date'.[51] The program was first announced in 2012.

Aside from negative interpersonal behaviours, there can be a felt expectation within military culture to appear 'strong' and not require support or care.[47] The Interim National Commissioner for Defence and Veteran Suicide Prevention's (the Interim National Commissioner's) *Preliminary Interim Report* highlights that 'military culture is actively fostered to prioritise a commitment to 'service before self'.[52] The RANZCP echoes the *Preliminary Interim Report*'s recommendations that an external review to evaluate the ADF culture regarding help seeking and mental health.[52]

Stigma

Action: Promote the availability of existing mental healthcare services provided by Open Arms and the level of confidentiality available.

Barriers to help-seeking include stigma (both self-stigma and intra-personal stigma).[20, 50] Stigma may be due to the military culture of a particular unit. RANZCP members have identified that there is a perception that the level of confidentiality provided for serving members and veterans is different to that in the community, and that this perception extends to Open Arms. Individuals may avoid help-seeking in an attempt to avoid stigma and protect their ongoing employment, deployment, and promotional opportunities.[47, 50] The RANZCP recommends greater promotion of the availability of existing mental healthcare services provided by Open Arms, and the level of confidentiality available.

Action: Expand peer worker initiatives and visibility of lived experience of a mental health condition in the military and for veterans.

The RANZCP highlights that solutions for reducing stigma and it's impacts include creating and maintaining a positive workplace culture, particularly around help-seeking, mental health support, and recovery. Evidence has found value in peer worker initiatives, or group interventions that are facilitated by those with a lived experience such as the Skills Training in Affective and Interpersonal Regulation (STAIR) program.[53]

The Interim National Commissioner's *Preliminary Interim Report* also highlighted that 'Defence should implement a cultural change and de-stigmatisation program throughout the ADF to normalise early access to mental health services.[52] Programs could include a peer support program (from enlistment or appointment) to help normalise help seeking within the ADF, and case studies where serving members who have experienced mental health concerns and/or a mood disorder have still been able to redeploy and/or progress through their careers.

Pillar two: Improved access to mental health services

The RANCP's recommendations for action contained within pillar two relate to the Royal Commission Terms of Reference matters -

> *b. a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues, such as the following:*
>
> *…i.v. the availability, accessibility, timeliness and quality of health, wellbeing and support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services".*

Psychiatry workforce shortages

Action: Meet demand for psychiatry services by increasing the psychiatry workforce.

The RANZCP recommends that suicide prevention efforts prioritise access to evidence informed mental healthcare such as psychiatry, for the treatment and prevention of mental health conditions and disorders arising in serving members and veterans.

Evidence has found that ensuring timely access to mental healthcare for serving members and veterans requires attention.[54] It is essential that action is taken to improve mental health outcomes for serving members and veterans. Mental healthcare for serving members and veterans should be informed by evidence and focused on long-term wellbeing and recovery. The RANZCP emphasises that support services for serving members and veterans should be underpinned by a skilled workforce, including psychiatrists, with specialised knowledge of military mental health.

Approximately, the number of psychiatrists treating DVA clients has increased between 2012–13 and 2019-2020, from 1111 to 1495 providers.[55] Shortages within the psychiatry workforce in Australia are well-known and a key focus of RANZCP policy and advocacy work. These shortages are often the cause of extensive wait times for an appointment with a psychiatrist, and are exacerbated in rural areas. The RANZCP is unable to provide a specific estimate of the wait time for a veteran to see a psychiatrist because this is variable. However, RANZCP members advise that an average wait time could be 6-10 weeks.

Attract psychiatrists to the sector

Action: Increase access to psychiatry services by attracting psychiatrists:

The RANZCP highlights that psychiatry workforce shortages also impact on the wellbeing and retention of the existing workforce by contributing to higher workloads and burnout.[56] Burnout among psychiatrists who work in the area of veterans' and military mental health may, on occasion, relate to the traumatic nature of the material.

The following actions may make the sub-specialty of veteran and military mental health a more attractive proposition for psychiatrists.

- **By reducing administrative burdens for psychiatrists.**

Most often, burnout among these psychiatrists relates to the complexity and time-demanding nature of the work. For example, additional reporting and administrative requirements for DVA and extensive case management duties for complex health conditions.

The RANZCP recommends efforts to reduce the burden of psychiatric reporting on psychiatrists. A request for an initial psychiatric report from the DVA typically contains 17 pages of questions. Creating a streamlined and standardised reporting process creates additional time for psychiatrists to offer to new patients, improving access for mentally ill veterans.

- **By consulting the RANZCP on amending the fee schedules which impact psychiatrists.**

Difficulties accessing psychiatric support can be frustrating for Base Medical Officers and General Practitioners. The RANZCP is advised that most private psychiatrists have very high caseloads with long waiting lists and therefore may not be in position to take on many, if any, new patients. To this end, the increased reporting and workload requirements for DVA compared to Medicare patients, combined with the reduced DVA fee schedule (compared to Australian Medical Association *Fees List*), remains a disincentive for psychiatrists to accept veterans as patients. This is similarly true for healthcare professionals working within the Bupa ADF Health Services Contract Provider Network and their fee schedule.

The priority of the psychiatrist is the treatment of the veteran's psychiatric condition. The DVA system can be confusing to both patients and psychiatrists, and patients may need the specialised support of an advocate or advisor to help them navigate their compensation claims.

The RANZCP supports the Interim National Commissioner's recommendation 6.9, which states that: **'**The Australian Government should consult the RANZCP on amending the DVA fee schedule for psychiatrists. This could include the Australian Government aligning DVA rates for psychiatrists who provide services to veterans with the rates for psychiatrists in the Australian Medical Association fee list.**'**[52] Similarly, the RANZCP supports the Productivity Commission *Compensation and Rehabilitation for Veterans Inquiry Report: A Better Way to Support Veterans* (Productivity Commission Inquiry report) recommendation that the DVA should commission an independent review into its health fee-setting arrangements.[57]

A specialised workforce for serving members and veterans

Action: Expand the number of uniformed psychiatrists, psychiatry trainees, and clinical psychologists in the ADF.

The RANZCP notes that there are few uniformed psychiatrists in the ADF. Currently, most uniformed psychologists in the ADF practice in an organisational or administrative role. Many do provide assessment and monitoring of mental healthcare provided by civilians in off-base private practice. Expanding the number of uniformed psychiatrists, psychiatry trainees, and clinical psychologists in the ADF will improve and increase our management of serving members. This recommendation is supported by the Government response to recommendations of the National Mental Health Commission *Review into the suicide and self-harm prevention services available to current and former serving ADF members and their families*.[58]

Action: Improve specialisation, education and training of the health workforce in defence and veteran care:

- **Via funding to develop Veteran Centres of Excellence and consultation services for veterans with severe, complex disorders.**

For serving members, GPs, psychologists, social workers, and registered nurses are employed by the ADF. Therefore, the ADF is accountable for training ADF-employed health professionals in specialised military care. Currently mental healthcare for veterans relies heavily on civilian health services provided by private and public health systems. While this may be suitable for some, the lack of specialised services and knowledge means that veterans can struggle to obtain the care they need, leading to sub-optimal mental health outcomes. This issue is compounded by a lack of exposure of health professionals in training to the unique needs and experiences of serving members and veterans, in particular the complex symptoms which may result from cumulative trauma exposure and nuances of military culture.

The RANZCP emphasises that the military has its own culture, and therefore the principles of cultural safety and need for culturally safe practice apply.[53, 59] There have been some efforts to address this in the psychiatric profession.[59] An understanding of military structure and culture is one aspect of providing culturally safe care to this client group and addressing cultural barriers to engagement in care.[53, 59] For further information, please see RANZCP Position Statement 105: Cultural safety.

Veteran Centres of Excellence and consultation services for veterans with severe, complex disorders should be developed and available to provide holistic, best practice care to veterans. The RANZCP notes the significant expertise and willingness to be involved in managing veterans and defence members of many psychiatrists. Such individuals usually have extensive experience in relevant disciplines such as adolescent and young adult psychiatry, mood disorders, workplace rehabilitation psychiatry, and trauma related disorders. The RANZCP highlights that engaging the expertise of these individuals in the management of this population is critical.

- **Via further funding for the Military and Veteran Psychiatry Training Program.**

The RANZCP has recognised the need to augment training in military and veteran health via further funding for the Military and Veteran Psychiatry Training Program (MVPTP). Support services for serving members and veterans should be underpinned by a skilled workforce, including psychiatrists, with specialised knowledge of military and veteran mental health. RANZCP Fellows who opt in to appear in the RANZCP's 'Find a Psychiatrist' directory can state their experience with various patient cohorts, including military and veterans. Psychiatrists may also list their experience on a personal website.

The RANZCP supports the Interim National Commissioner's recommendation 6.7, which states that:

> *"The Australian Government should implement programs and incentives for mainstream healthcare professionals to improve their understanding of issues relevant to effectively treating veterans (i.e. veteran cultural competency). The Australian Government should build upon the Royal Australian and New Zealand College of Psychiatrists (RANZCP) training pilot – which trained a limited number of psychiatrists in veteran and military health – by providing additional funding to train more psychiatrists in these areas. Emphasis should be placed on ensuring that the psychiatrists who receive this training are located throughout the nation, particularly in areas with high demand among veterans and low availability of psychiatrists. The Australian Government should ensure that the training program undergoes ongoing monitoring and evaluation (by the RANZCP or other appropriate organisation) to make sure it is producing professionals who meet the needs of the veteran community."*[52]

Currently the MVPTP funds ten specialised psychiatry training positions per year for three RANZCP training years (2022 to 2024). The MVPTP is a DVA initiative that provides funding to health organisations to support training experiences in facilities who predominantly work with military and veteran personnel, are based within an area with high defence personnel presence and/or are DVA service providers.

The training program aims to strengthen workforce capability to deliver psychiatric services specific to the unique needs of veterans and military personnel. Currently, funding for the MVPTP posts will be available for three training years (2022 to 2024). There are 4 posts in New South Wales, 3 posts in Queensland and 1 post in South Australia, Victoria and Western Australia. The RANZCP is hopeful that this funding will be continued beyond 2024. This is a vital step, and many of the positions utilise the flexibility and wide experience of the private sector. It is noted that key base areas, Darwin and Canberra (Kapooka) are currently not represented. The RANZCP is examining strategies to remedy this.

- **Via trauma-informed care and military and veteran training for the wider workforce.**

The RANZCP additionally recommends the Government requires that training for those working with serving members and veterans includes competencies relating to trauma-informed care and vulnerable populations such as serving members and veterans. Trauma is a key risk factor for suicide and a trauma-informed approach can enhance recovery. For more information on trauma-informed practice, please see the RANZCP Position Statement 100: Trauma-informed practice.

The RANZCP notes that the majority of serving members and veterans are treated by private mental health practitioners. Many of these practitioners have considerable experience, some of it lived experience, with military culture and processes. Engagement with training programs offered by the RANZCP is proceeding but limited.

There were several recommendations made in the Senate Foreign Affairs, Defence and Trade References Committee inquiry into suicide by veterans and ex-service personnel report, *The Constant Battle: Suicide*

by Veterans.[60] The RANZCP acknowledges some success in implementing these recommendations. The RANZCP welcomes the opportunity to work with the Government to advise on mental health education, training, and development for primary healthcare providers. Peer review groups with a military and veteran focus is one option to build capacity.

- **Via expansion, organisation and standardisation of registrar and psychiatrist training in the mental healthcare of military personnel and veterans.**

The RANZCP recommends the expansion, organisation and standardisation of registrar and psychiatrist training in the mental healthcare of military personnel and veterans. Building workforce capacity in relation to the treatment of veterans is critical to ensuring mentally ill veterans have access to sufficient treatment.

Committing to long-term funding for training and training supervisor posts under the Psychiatry Workforce Program would contribute to achieving this recommendation. The RANZCP has the capacity to support further psychiatric specialist trainee positions and recommends that these receive further funding to provide training in veterans' care.

The RANZCP emphasises that workforce development must also ensure that those delivering mental health support to veterans also have adequate capacity to care for diverse community members, including provision of support that is culturally safe, and appropriately supports those with disabilities.

The efficacy of a standardised training programme for military and veterans' issues is reliant on the sufficient training of care workers who support mentally ill veterans. The RANZCP submission to the Care Workforce Labour Market Study highlighted the opportunity to invest in a care workforce that has the capacity to treat vulnerable groups with specific needs (such as veterans). This training may include trauma informed practice, family therapy skills, AOD, Dialectical Behavioural Therapy (DBT), human rights facilitation, and distress tolerance skills.

The RANZCP welcomes the opportunity to work with the Government to advise on mental health education, training, and development for primary healthcare providers.

Pillar three: A lifetime wellbeing approach

The RANZCP's recommendations for action contained within pillar three relate to the Royal Commission Terms of Reference matters -

> *b. a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues, such as the following:*
>
> *…i.v. the availability, accessibility, timeliness and quality of health, wellbeing and support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services".*

Tailored support

Tailored continuum of care for serving members and veterans

Action: Provide a tailored continuum of care for serving members and veterans which has a focus on lifetime wellbeing.

The RANZCP supports the Productivity Commission statement that services must acknowledge that serving members, veterans and their families have unique needs resulting from military service.[57] A tailored continuum of care should identify risk and protective factors over the lifetime, and address appropriate prevention and rehabilitation treatment services for current and former defence force members. A continuum of care should consider a range of issues and conditions that people may have when they leave the ADF, which may not usually be considered in civilian healthcare. Issues may include alienation from civilian life, difficulties in restoring interpersonal connections, challenges in social and/or occupational functioning and complex feelings of guilt, grief, blame, mistrust, control, withdrawal and/or rage.[61] Difficulties in transitioning to civilian life may relate to social, occupational and/or psychiatric functioning and may be experienced as feelings of not belonging or a loss of identity, which may be factors in the suicidal process.[62] Additionally, the RANZCP recognises that trends in alcohol and drug use by serving members and veterans may differ from the general population, which should be addressed within the health services accessed by this population.[63, 64]

Tailored support in consideration of families, carers, and households.

Action: Consider families and carers in support systems and plans.

The RANZCP believes that the best outcomes can be achieved through a collaborative, multidisciplinary, all-of-community approach to suicide prevention. Connections between services are needed to form the 'continuum' of care to ensure that serving members and veterans do not fall through the gaps. Many cases of suicide demonstrate issues within mental health systems and quality of care issues. An important part of this collaborative care includes the informal care workforce. Mental health service design should incorporate the role of community, including family, friends and carers, in supporting serving members and veterans, and support should be made available for family, friends and carers.

Case study 1:

> *Ian* self-discharged in 2011 after three deployments. Over the next three years he became increasingly depressed and angry. His wife sought assistance from the DVA and was rebuffed. Ian* attempted civilian work but became concerned at the number of mistakes he was making and his frequent fights with colleagues. He developed an amphetamine addiction, was arrested and subsequently jailed.*
>
> *Whilst in jail he was assessed by a psychiatrist who diagnosed him with PTSD. He also developed a cardiomyopathy (viral induced heart failure) and had a stroke aged 38. There was perfunctory medical intervention with anticoagulants. He attempted suicide in jail.*
>
> *Ian entered treatment in 2017 and has remained methamphetamine-free since 2018. He has had two transient ischemic attacks which were not well managed in the public sector.*

He obtained a gold card in 2021 and reinvestigation in the private sector showed a congenital cardiac malformation (patent foramen ovale) which was easily resolved with a percutaneous cardiac surgery.

This case study demonstrates to the RANZCP the importance of connections between services. In this example, connections with correctional services led to active engagement between the patients and mental health services. In this case, this effort was led by a volunteer. This case study also demonstrates that Ian's* wife had sought support from the DVA following Ian's discharge. Increased early intervention support for people like Ian* and his wife is an opportunity to prevent conditions from escalating. It is important to acknowledge that help-seeking may first come from a serving member or veteran's family, carer, or support person.[65]

In the 2021 Census, 5.3% of Australian households reported at least one person who had previously served, or was currently serving in the ADF.[29] The Census also found that 13% of veterans need assistance with everyday activities of self-care, mobility or communication.[29] These figures demonstrate how many Australian households are impacted by systems supporting the health and wellbeing of serving members and veterans.

The RANZCP highlights that family and community attachments and support are considered to be a protective factor against suicide.[4] Studies consistently find that social isolation is a significant risk factor for suicide.[1, 16] Experiences of trauma can impact social function and relationships, affecting all people involved and compromising social supports.

A restorative and trauma-informed approach is needed for serving members and veterans, with families, carers, or support persons at the centre of care. This approach is recognised by RANZCP members as an effective measure, particularly when assessing and treating victims of bullying in the ADF. For more information, please see RANZCP Position Statement 76: Partnering with carers in mental healthcare.

Tailored support to different cohorts

Action: Fund research to gauge periods and cohorts that are at a high risk of suicide.

The RANZCP highlights the importance of further research to gauge periods and cohorts that are high risk. For example, escalation from suicidal ideation to plans and attempts often occur in the first year of ideation in younger people.[17] Younger males of lower ranks in the ADF were found to be at a higher risk of suicide and suicidal behaviours.[10] Increased suicidality has also been observed in those who were subject to physical or emotional abuse in their childhood.[47] As an additional example, clinical experience suggests that ADF members who have transitioned out after short periods of service and without deployment commonly report musculoskeletal issues, or interprofessional issues such as bullying and sexual trauma.

Contemporary veteran cohorts have very distinct needs, including vocational and training support, from those of earlier veteran cohorts. It is also important to note that with increasing age comes a variety of other risk factors and service needs not distinct to veterans, including the increased probability of non-service related physical injuries, greater need for aged care services and other medical comorbidities.

The RANZCP notes that one of the key challenges faced by governments is the provision of effective, accessible and appropriate support over the lifetime of serving members and veterans, in what is currently a compensation-based system. Serving members and veterans are a diverse group and tailored approaches to meet their unique needs should be integrated into service planning and delivery.

Tailored support to the individual: person-centred care

Action: Provide a gold card to any veteran, or limit this to veterans who were deployed during service.

Clinical assessment and care will be more effective when an individual's needs are identified and prioritised, and a strong therapeutic partnership is developed. The DVA currently manages cases based on condition rather than a more holistic, person-centred approach. Investigating whether a condition is service-related is expensive and administratively burdensome. The RANZCP notes that it may be simpler and cheaper to provide a gold card to any veteran, or limit this to veterans who were deployed during service.

Action: Ensure the number of complex case managers meets demand.

The RANZCP recognises that the social determinants of health is a key concept which applies to the health and wellbeing of veterans. Veterans may have a variety of needs which span service types relating to the social determinants of health, including healthcare, housing, addiction, employment, and other social support services.

RANZCP members highlight that veterans often have no single point of management for meeting their needs, resulting in an overwhelming and confusing experience for a recently discharged veteran. Proactive steps that have been taken in this regard, including the provision of Clinical Case Coordinators from Open Arms, and complex case managers by the DVA via the Coordinated Client Support service model and the Wellbeing and Support Program.

However, psychiatrists report that case managers are in short supply, and often can only work with the veteran for a limited time. Ensuring that the number of complex case managers employed can meet demand would enable more veterans to be supported in a holistic way. The outcomes for such programs or services should be publicly reported to increase understanding of how many veterans are assisted by such programs, for how long, how they connect with services such as mental health and housing support services, and how often this occurs.

A 'lifetime wellbeing' approach

Action: Consider the lifespan of a serving member when developing and reforming support systems for serving members and veterans.

The RANZCP strongly supports the need for mental healthcare to be seamless, ensuring continuous access to services throughout enlistment, training, deployment, discharge and ongoing civilian life. There is strong evidence to suggest that suicide prevention interventions should be tailored across the lifespan.[4] The RANZCP emphasises the need to adopt a lifetime wellbeing approach for those who serve in the ADF, through all governance mechanisms which service this population. Recent evidence provides insight into high risk cohorts and phases through the lifespan of a serving member, and can be used to provide tailored mental health services and help to prevent suicides.[10] The approach should consider pre-recruitment, service, transitioning out of service, and post-service, and be person-centred, tailored to individual risk factors in addition to existing conditions.[4]

Productivity Commission:

> *"A future veteran support system needs to have a focus on the lifetime wellbeing of veterans. It should be redesigned based on the best practice features of contemporary workers' compensation and social insurance schemes, while recognising the special characteristics of military service. This will change the incentives in the system so more attention is paid to the prevention of injury and illness, to rehabilitation and to transition support."*[57]

The DVA's *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023* vision states the changing focus from an illness model to a wellbeing model.[16] The RANZCP emphasises that these models are not contradictory. A lifetime wellbeing approach must focus on providing good care: both treating illnesses and conditions and improving social engagement and quality of life.

Transitioning out of service

Action: Provide access to intensive transition services, tailored to different forms of discharge and transition.

Transitioning out of service is known to be a challenging time. Barriers to mental health support do not end upon leaving the service. During their transition into civilian life, veterans are confronted by complex systems, both legislatively and administratively, of compensation, rehabilitation and general support.[57] Rates of completed suicide in ex-serving ADF males are more than double that of serving ADF males, with increased risk for suicidality observed among those who had recently transitioned out of full-time service.[10] Whilst there are many reasons, the loss of the camaraderie, identity, sense of purpose and uncertainties about the future are likely to be factors in suicides. In one study, 21% of those transitioning out of service had suicidal ideation, a significantly higher percentage than that in the community.[47]

The RANZCP highlights that different forms of discharge (voluntary, medical or other involuntary) carry different types of risk. For example, those who had been medically discharged from the ADF were found to be at a higher risk of suicide and suicidal behaviours.[10] Veterans who have been medically discharged are reported as being at 1.9 times higher risk of suicide in comparison to those who had voluntarily discharged.[10] About 14.4% of those who leave the ADF do so for 'involuntary medical' reasons.[66] This exemplifies the need to integrate pathways across health, social, and veteran-specific services.

Transition programs for those leaving the ADF should identify 'at-risk' groups and provide these groups with access to more intensive supports. Such services should include support for claims case management, healthcare support, employment assistance and social connectedness programs.[52, 60] Treating practitioners should be consulted regarding any plans for what transition supports might be needed for their patients. RANZCP members highlight that the paperwork involved with transitioning out of service is overwhelming to many of their patients, with insufficient assistance.

Communication between care providers

Action: Improve communication with treating teams for holistic care.

The RANZCP advocates for mental healthcare to be holistic, person-centred and responsive to the needs of an individual. Clear treatment and referral pathways must be available where the patient is heard and matched to the intervention level and type of service which suits their needs. This often requires collaboration between multidisciplinary teams. For more information, please see RANZCP Position Statement 37: Principles for mental health systems.

- *Base Medical Officers*

RANZCP members have also highlighted the need for improved communication between psychiatrists, ADF Base Medical Officers and ADF Rehabilitation Counsellors. The limitations of the employment environment may not be adequately understood by the treating team, nor the limitations and remaining strengths of the individual adequately understood by Command. Patients of RANZCP members have also reported that Individual Welfare Boards are ineffective. A common complaint is that the elements of Command responsible for implementing recommendations from the Welfare Board do not attend.

- *Rehabilitation care providers*

RANZCP members have previously raised concerns in relation to some rehabilitation care providers, including varying quality of services provided, noting that many rehabilitation care providers provide excellent care. Since the RANZCP has communicated with the DVA regarding communication issues, members have been pleased with improved liaison over the last 6 months. Varied accountability for acting on psychiatrist recommendations can reduce the impact of multidisciplinary care.

- *Claims case managers*

RANZCP members highlight that claim case managers rarely reach out to treating practitioners for medical advice. The onus often lies on practitioners to attempt to find and communicate with case managers, which can be a complicated process. DVA decisions regarding rehabilitation, treatment access and income can be made in isolation from a veterans' treating team or rehabilitation worker, which interrupts the flow and progress of their treatment. In some cases, case managers have described sharing information with the treating practitioner as a conflict of interest.

Case study 2:

> *Gerry* is under my care. He was discharged from the ADF in 2021. He has a history of combat exposure with multiple deployments. He had experienced being under fire, returned fire and witnessed a number of distressing incidents. His discharge from the military followed a period of satisfactory treatment of his PTSD from 2019 onwards. He experienced a significant relapse in early 2021 following the suicides of three individuals known to him. Following his suicide attempt, he was hospitalised for three weeks with good effect.*
>
> *Following discharge from hospital his isolation and social anxieties were noted as major barriers to full recovery. Engagement in study was recommended and discussed with the DVA.*
>
> *Gerry* has a background in the arts, he won a drama prize as a youth, and is skilled in a variety of manual tasks including metal work and woodwork. Gerry* was accepted into a university arts course through early Summer 2021 and this was approved by his DVA worker in December 2021. With considerable support, Gerry* was able to attend university and push his workload to being two months ahead in his tasking.*
>
> *Abruptly in April 2022, a different DVA worker cancelled the course. Gerry* was told the course is not likely to lead to employment, but that Gerry* had good grounds to appeal the decision. The university did not agree with the conclusion that the course was not likely to lead to employment. At no point did the DVA approach the university to investigate employment opportunities.*
>
> *The DVA decision to withdraw funds was made without reference to his treating team. For Gerry* to wait while a decision is made was deleterious to his mental state. His treating team continued to support and closely monitor him for a resumption of alcohol misuse or worsening mood.*
>
> *Following representation by his treating team, in this case, to the Ministry of Veteran's Affairs, the adverse decision concerning rehabilitation was overturned and he has resumed to study with benefit. However, without this level of input his condition may have progressively worsened.*

This case study was provided by a psychiatrist about a veteran with a mental disorder, early in the transitional period following service. The case study exemplifies the impacts of what can occur where there is no liaison with the veteran's treating team.

Rehabilitation for psychological injuries

Response to psychological injury in the ADF

Action: Improve processes for rehabilitating psychologically injured soldiers within the workplace.

'Return to work' programs are provided inside the ADF and aim to be progressive in comparison to other industries. Many of these programs have adapted strategies to progress the treatment and rehabilitation of injured workers. The RANZCP highlights that these programs should provide person centred support and utilise non-operational return to work positions which optimise chances of a successful occupational rehabilitation. The workplace response and follow-up contact following worker injury is a major influence in a successful return to work.[67] This response is in part determined by the mental health literacy of Commanding Officers (COs).

The RANZCP highlights that there are many sources to draw on for the improvement of processes for rehabilitating psychologically injured soldiers within the workplace. The Royal Australasian College of Physicians (RACP) and the Australian Faculty of Occupational and Environmental Medicine have recently released a paper *It Pays to Care: Bringing evidence-informed practice to work injury schemes helps workers and their workplaces - a values and principles based approach*.[68] The RANZCP provided a submission in July 2021 to the development of this paper. There is also a *National Return to Work Strategy 2020-2030*.[69]

From an economic perspective, each serving member represents significant community investment, including training costs. This indicates that there is significant economic value to retention of serving members. Additionally, the rehabilitation and retention of serving members following psychological injury is likely to improve the workplace culture and perception regarding psychological injury, by promoting a focus on mental wellbeing and recovery. Rehabilitated serving members represent hope and recovery, an example that a mental health presentation does not automatically lead to discharge. Rehabilitated serving members are also valuable for the guidance and support that they can provide to other serving members.

Mental health literacy of Commanding Officers

Action: Improve the consistency of response to mental health presentations inside the ADF.

The mental health literacy of COs and treatment providers is unknown, in particular in reference to mental health management of serving members and rehabilitation options. RANZCP members highlight that patients report experiences of bullying, ostracism and micromanagement within the ADF. These experiences are reported as being exacerbated for serving members with a mental or physical health condition.

Patients of RANZCP members also report that command responses to presentation and self-identification of mood disorder or symptoms inside the ADF is not consistent between units and depends on how receptive or supportive individual COs are. The attitudes of COs are an important facet of providing mental healthcare to serving members. The skill and experience of COs in responding with compassion and practicality to these presentations has a strong impact on mental health presentations, treatment adherence, and symptomatic and functional outcomes, both in service and in transition. The link between workplace support and a successful return to work has been repeatedly demonstrated.[70]

Methods of improving the consistency of responses to mental health presentations includes training to improve mental health literacy in those in leadership positions such as COs, and at Garrison Health personnel. This recommendation aligns with the aims of the *Defence Mental Health and Wellbeing Strategy 2018-2023* (the Strategy).[71] While the Strategy notes that mental health training is provided to those in leadership positions, the RANZCP highlights the need for this to be strengthened to ensure a safe workplace culture. Mental health literacy training must be tailored to a military environment, and could be developed in consultation with organisations that have that have demonstrated capacity.

RANZCP psychiatrists have noted that when COs have been provided with support, such as a framework for understanding mental health conditions and implementable advice, they can be a pivotal support in an individual's rehabilitation.

The RANZCP highlights that any training developed must account for the existing culture and mental health stigma, and include elements of training which support help-seeking, career retention, minimise barriers to care, and focus on trauma-informed care. This is due to the association between PTSD and suicidality in Australian veterans.[72]

Case study 3:

> *When responding to physical injury, we create a rehabilitation plan which may include physiotherapy, light running, extra personal training (PT). With a psychological injury, no holistic rehabilitation plan is created.*
>
> *I have found the organisation has become too risk-adverse when dealing with individuals with mental health concerns. Commanders don't seem to be trained enough in dealing with members that are fighting with mental health concerns. When an individual throughout their rehabilitation falls over in any way (not dissimilar to a physical injury) there appears to be a complete loss of trust in the individual achieving any goals, and remove jobs that may challenge an individual, this means the members become bored with what they are doing, which removes any sense of achievement. This in itself is enough for members to slowly sinks into a lack of trust in themselves and their abilities to achieve anything, which contributes to the slow descent into depression.*
>
> *I believe we need to create a more comprehensive Command Course that educates on better ways of managing mental health, to give managers a better understanding on what an individual goes through, as well as challenging an individual and creating self-worth in both themselves and the organisation.*
>
> *This is a simple analogy but it may help to articulate my idea: Member identifies as having a mental health issue, member starts with psychology, out of this a plan is created. Simple example, starts with administration task and extra PT, carries dummy weapon, starts driving white vehicles, help with conducting Weapons Handling Test (WHT), helps with range supervisor, is deployed on exercises driving green fleet vehicles and help running of the exercise, conducting their own WHT, and then range shoot and then, with psychology approval, back to fully deployable. In some cases a posting plan could be created, where a member could identify where they believe a better workplace rehabilitation plan could be created, this could also include a posting ban for a given amount of time.*
>
> *Mental health coaches need to be created, these individuals would be able to coach members through the process of returning them to full deployable, and help create and coach them through their rehabilitation plan. (I have been told this role is done through Open Arms, however with my exposure in Open Arms (VVCS) there is no way they are able to provide an extensive Workplace Rehabilitation Plan for Mental Health).*

This case study was written by a senior-ranking, non-commissioned officer. Following their diagnosis of PTSD their duties were promptly withdrawn without consultation with either themself or their treating team. To provide holistic care, it is productive to connect mental health treatment providers caring for serving members with those involved with managing the workplace context.[54, 73] Managing reactions to the challenge to existing beliefs of those in leadership positions will be important.[54, 73]

Pillar four: Integrated systems of governance

The RANZCP's recommendations for action contained within pillar four relate to the Royal Commission Terms of Reference matters -

> *"g. any systemic issues in the nature of defence members' and veterans' engagement with the Department of Defence, the Department of Veterans' Affairs or other Commonwealth, State or Territory government entities (including those acting on behalf of those entities) about support services, claims or entitlements relevant to defence and veteran deaths by suicide or relevant to defence members and veterans who have other lived experience of suicide behaviour or risk factors, including any systemic issues in engaging with multiple government entities;*
>
> *h. "the legislative and policy frameworks, administered by the Department of Defence, the Department of Veterans' Affairs and other Commonwealth, State or Territory government entities, relating to the support services, claims and entitlements referred to in paragraph (g)".*

Governance mechanisms

Action: Strengthen and consolidate governance mechanisms to promote accountability

The RANZCP affirms that suicide prevention requires a comprehensive approach that spans systems, organisations, communities, cultures and environments, combining treatment, support and intervention, and bridges gaps between fragmented services.[74] Mental health systems and services must be grounded within social and economic structures and policies that enhance wellbeing and minimise distress, enabling compassionate and holistic care. Efforts to improve and connect governance mechanisms, policies, legislation, and practices that impact on the mental health of serving members and veterans are required.

The Productivity Commission highlighted the need for role clarification and improved accountability between the Department of Defence and the DVA for veteran wellbeing, to prevent service gaps including during periods of transition.[57] The RANZCP recommends that the Australian Government provide targeted and seamless support for serving members and veterans through one consolidated government body which has appropriate levels of resourcing and staffing. It is additionally vital that the Australian Government embed medical specialist expertise within government bodies that work with current serving members and veterans, with specific representation from psychiatry.

The RANZCP's submission to the *Draft Veteran Mental Health and Wellbeing Strategy and Action Plan 2020-23* encouraged the DVA to establish an Independent Oversight Committee to support strategic collaboration with the national mental health and suicide prevention agenda, the Department of Defence, DVA, and all states and territories. This is complementary to the Interim National Commissioner's advice 'an independent body should oversee the Australian Government's monitoring, public reporting and evaluation of the implementation of recommendations associated with veteran suicide'.[52]

It is critical that defence and veteran suicide efforts are connected in with each other, and with wider suicide prevention efforts, including collaboration with the National Suicide Prevention Office, which was announced in May 2021. Ensuring a collaborative approach will lead to a greater understanding of the individual, environmental and systemic factors involved in suicide.

Policy frameworks

Action: Introduce an effective mental health and suicide prevention strategy for serving members and veterans

The RANZCP strongly supports the introduction of a more effective mental health and suicide prevention strategy for serving members and veterans. The RANZCP has previously advocated for this in the response to the Productivity Commission *Inquiry Draft Report* in February 2019. The Productivity Commission recommended a 'whole-of-life' policy should be developed collaboratively, utilising external expertise, and ensuring collaborative cross-agency processes.[57]

The RANZCP highlights that a new strategy should be guided by serving members and veterans, with significant clinical input from relevant health professionals including psychiatrists. Greater engagement with health professionals is particularly important to ensure that there is sufficient clinical expertise and governance to effectively guide reform programs to better meet the mental health needs of veterans.

With the DVA's *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023* and superseded *Veteran Mental Health Strategy: A Ten Year Framework 2013-2023* both expiring in 2023, now is the time to act on this recommendation.[16, 75] The RANZCP's MVESPMHN Committee and the DVA Chief Officer's Expert Advisory Committee are valuable points of contact for the Government in developing any new policies.

Legislative frameworks

Action: Adapt legislative frameworks:

- **To reduce legislative complexity.**

The RANZCP is committed to ensuring Australian military personnel and veterans are given the best chance of receiving appropriate compensation and assistance. Psychiatrists report finding the legislation awkward to work with.

The RANZCP supports the recommendation made in multiple reports to reduce complexity and harmonise entitlements across the three main Acts:

- the *Military Rehabilitation and Compensation Act 2004* (MRCA)
- the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988* (DRCA)
- the *Veterans' Entitlements Act 1986* (VEA).[60, 76]

The Government response to the Productivity Commission's Inquiry report acknowledged the need for this and recognised that 'most recent legislation, the Military Rehabilitation and Compensation Act 2004, will be the primary veterans' legislation going forward and there will be a "long tail" of the two earlier Acts, the Veterans' Entitlements Act 1986 and the Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988.'[77]

- **To reframe the purpose of the legislative framework.**

The RANZCP highlights the higher purpose of the legislative framework is to improve the mental health and wellbeing of veterans. The Interim National Commissioner additionally recommends that 'the current framework, which is premised on a compensation model, should be replaced with a wellbeing model, which incorporates concepts of social insurance more aligned with the National Disability Insurance Scheme. This model should include safety net access to payments.'[52]

Pillar five: A growing evidence base that is utilised effectively

The RANZCP's recommendations for action contained within pillar five relate to the Royal Commission Terms of Reference matters -

> *"j. any matter reasonably incidental to a matter referred to in paragraphs (a) to (i) or that [the Commissioners] believe is reasonably relevant to [their] inquiry."*

Growing the evidence base

Finding the patterns of suicidality in serving members and veterans is the key to preventing future suicides. The RANZCP acknowledges that the DVA has a *Strategic Research Framework 2019-2021* (the Framework). However, this section identifies several opportunities for consideration and improvement of the Framework.

Action: Invest in the collection of further data for system improvement.

Research and evaluation are key in building an evidence base. Opportunities for research should be prioritised as an essential element for improving serving member and veteran mental healthcare, treatment, and outcomes. Research is essential for building knowledge and an evidence base to support systemic strategies, service design and delivery, as well as treatment. The RANZCP recommends that further research is funded, highlighting that research often focuses on single diagnosis studies, whereas psychiatrists see patients who often have dual or multiple diagnoses. This is particularly true for a PTSD diagnosis, which occurs in serving members and veterans at high rates.[44] It is worth noting that those with multiple disorders are also considered to be at a heightened risk of suicidality.[47]

The RANZCP highlights that funding must be allocated to Australian research and university partnerships to generate further research and advancements in the field. Establishing long-term research programs will help guide evidence informed service delivery, with an emphasis on the collection and use of statistics for veterans, female serving members and any other identified knowledge gaps in Australia. Research questions must be strategic and build on the existing body of knowledge.

The RANZCP highlights the key priorities for research in relation to the mental health of serving members and veterans as being the identification of service gaps, assessing quality of care, assessing psychiatric treatment, and improving treatments and treatment outcomes. Research findings must be consistently and sensitively communicated to participating serving members and veterans to acknowledge their contributions.

Action: Develop a more strategic approach to research.

The RANZCP recommends that the approach to research on the mental health of serving members and veterans is coordinated, consistent and strategic, developed by experts in the field and in consultation with serving members and veterans. The Productivity Commission Inquiry report held research as a central priority, recommending the development of a veteran research plan and an Expert Committee on Veteran Research to inform, monitor, and report on the research plan.[57] The RANZCP has strongly supported this recommendation in the March 2020 response to the *Draft Veteran Mental Health and Wellbeing Strategy and Action Plan 2020-23,* highlighting that the Productivity Commission recommendations could be better addressed.

Both the Productivity Commission Inquiry report and the Senate Foreign Affairs, Defence and Trade References Committee report *The Constant Battle: Suicide by Veterans* highlighted the need for a more strategic approach to research. The latter emphasised the importance of research governance and oversight, and the setting of research priorities and planning, including annual updating and publication of that plan.[57, 60] The RANZCP highlights that public access to such plans and evaluations of plans is important.

Action: Nurture experts in the field of serving member and veteran mental health.

Prioritisation of the academic workforce is a key strategic consideration and necessary to sustain Australia's research capabilities into the future. Strong partnerships to connect the academic workforce with the governance mechanisms responsible for the care of serving members and veterans are key. The RANZCP submission to the DVA *Draft Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023* recommended investment to create and nurture experts in the fields of serving member and veteran health and wellbeing, to not only work with veterans in the community, but to generate further research and advancements in the field. The RANZCP highlights that the Royal Commission has the opportunity to support this recommendation.

Action: Establish better processes for consistent data collection and evaluating services.

There is an opportunity to establish better processes to consistently collect data and evaluate the effectiveness of existing services for serving member and veteran mental health.[76] The RANZCP supports the Interim National Commissioner's recommendation that the implementation of initiatives, programs and trials aimed at improving serving member and veteran mental health and wellbeing should be monitored and evaluated.[52] Evaluation is important because it can reveal strengths, weaknesses, and unintended consequences of current practices and services. Findings from program and service evaluation can be used to improve future interventions and facilitate better outcomes for serving member and veteran mental health and wellbeing.[49]

One method of improving data collection is to ensure that psychological autopsies are conducted.[6] Conducting psychological autopsy is considered a rigorous method of determining the presence of mood disorder, as it is well known that many people do not receive a diagnosis or treatment.[4, 5] The RANZCP recommends that full psychological autopsies are conducted and the problems within service delivery are investigated for those who die by suicide.

The RANZCP suggests the Government establish a national data centre in order to collect nationally consistent data on mental health. This will support establishment of clinical registries which enable the collection of wider demographic information and key risk factors for suicide, e.g., mental illness and addiction comorbidities. Clinical registries provide the potential to improve understanding of the factors that contribute to quality care – informing and driving change in policy and practice, and improving patient outcomes.[78]

The RANZCP highlights that it is critical that any reviews of mental health services for military personnel and veterans should include experienced psychiatrists with knowledge of the health systems involved, as is done in other domains of health planning.

Action: Develop a strategy to improve PTSD treatment outcomes.

As per the trauma section of this submission, the RANZCP advocates that more effective treatments for MDD and PTSD are needed to support the best possible wellbeing for serving members and veterans. Thorough evaluation of emerging treatments for PTSD such as Repetitive Transcranial Magnetic Stimulation (rTMS), ketamine, and psychedelic and empathogen agents needs to occur with large, multi-site prospective studies required. Such an undertaking should occur in a way that is organised and funded appropriately, such as developing a strategy focussed on improving PTSD treatment outcomes, including an ongoing commitment to fund high quality research in this area using initiatives such as the Medical Research Future Fund.

For more information on the RANZCP's current recommendations for use of such treatments, please see the RANZCP Position Statement 79: Repetitive Transcranial Magnetic Stimulation, Clinical Memorandum:

Use of ketamine for treatment-resistant depression, Clinical Memorandum: Therapeutic use of psychedelic substances, and the clinical practice guidelines for mood disorders.

Making use of existing resources

Action: Utilise the existing evidence on military and veteran mental health.

The RANZCP highlights that there are opportunities to map and prioritise further analysis of existing datasets which are underutilised due to lack of funding. The *Transition and Wellbeing Research Program* (TWRP) is a comprehensive study.[79] The RANZCP highlights that the continued surveillance of this population using a longitudinal methodology, as explained in the TWRP key findings, would provide a deeper analysis. This analysis could better examine the progression and determinants of suicidality during transitions, patterns in diagnoses, service use, barriers to mental health support, and health and treatment outcomes.

There are several other high-quality studies where such logic applies, including the *Deployment Health Surveillance Program*. Reinstitution of this program must include non-deployed personnel as a priority. The RANZCP also anticipates the public release of the Phoenix Australia, ADF, and DVA *Wellness Action Through Checking Health Project* final report.

Recommendations from existing high quality research in relation to the mental health of veterans should be utilised to inform the development of policies and services moving forwards. The implementation of all recommendations made through inquiries associated with veteran mental health and wellbeing must be monitored and findings made publicly accessible.[76]

Action: Utilise the existing expertise in military and veteran mental health, trauma, and suicide prevention.

Considering the special expertise of psychiatrists in military and veteran mental health, trauma, and suicide prevention, it is important for psychiatrists to hold a more influential and nuanced role in the design and implementation of mental health services, systems and models of care for serving members and veterans. The RANZCP contains expertise that is useful to the Royal Commission and governments. We welcome any opportunity to provide input on these matters, and any matter that impacts on the mental health of ADF members and veterans.

For example, the Stakeholder Engagement Strategy within the DVA *Veteran Mental Health and Wellbeing Strategy and National Action Plan 2020-2023* was disappointing and illustrates that much of the engagement, including with health professionals had focussed on status updates and monitoring. The RANZCP urges that the next iteration create additional opportunities for engagement and consultation with experts in the field of veteran mental health, including psychiatrists and veteran's organisations.

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