

INDEPENDENT STUDY INTO SUICIDE IN THE EX-SERVICE COMMUNITY

initiated by the Minister for Veterans' Affairs,
the Hon Alan Griffin MP

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The Hon Alan Griffin MP
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Dear Minister

I take great pleasure in submitting the *Independent study into suicide in the ex-service community*.

Modern armed forces engaging in modern warfare and peacekeeping unavoidably place very high demands and stresses on their members. This can have adverse effects on the mental health of some members. Many of these only become apparent sometimes only many years after discharge, DVA is well aware of this and has put in place a Mental Health Strategy and a range of health, welfare, rehabilitation services aimed at their prevention and amelioration.

Nevertheless I believe more can be done to further develop and modernise these services and programs. A number of proposals to do this are set out in the report for your attention and consideration.

Yours faithfully



(Prof) David Dunt

Acknowledgments

I wish to thank Ms Naomi Berman particularly who participated fully in all parts of the study and had carriage of the public submissions process. She also was responsible for the write-up of:

- Appendix 1 Emergent themes from public submissions to the Independent study into suicide in the ex-service community; and
- Appendix 5 Rapid literature review of barriers to mental health care in the ex-service community including stigma;

Dr Colleen Doyle wrote Section 3 Summary of current research and literature review on suicide in veterans with extra input from Dr Jo Robinson.

Dr Susan Day was responsible for the write-up of:

- Appendix 7 Rapid literature review of interventions to reduce alcohol misuse; and
- Appendix 8 Rapid literature review of combat exposure and PTSD.

Mr Peter Feldman was responsible for the write-up of:

- Section 4 Rapid literature review of PTSD and best-practice treatment; and
- Appendix 3 Rapid literature review of Adjustment disorders and best-practice treatment.
- Appendix 8 Rapid literature review of suicide prevention programs;

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Glossary

AAT	Administrative Appeals Tribunal
ACPMH	Australian Centre for Posttraumatic Mental Health
ADAPCP	Alcohol and Drug Abuse Prevention and Control Program
ADF	Australian Defence Force
ADFRP	Australian Defence Force Rehabilitation Program
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and Other Drugs
APPVA	Australian Peacekeeper and Peacemakers Veteran's Association
APS	Australian Psychological Society
AREP	Alcohol and Rehabilitation and Education Program
ASIST	Applied Suicide Intervention Skills Training
ATODS	Alcohol, Tobacco and Other Drugs Services
AUDIT	Alcohol Use Disorder Identification Test
AWOL	Absent Without Leave
BAI	Brief Alcohol Intervention
BEST	Building Excellence in Support & Training
BPA	Bureau of Pensions Advocates
CALD	Culturally and Linguistically Diverse
CDF	Chief of the Defence Force
CIDI	Composite international Diagnostic Instrument
CLU	Client Liaison Unit
CMVH	Centre for Military and Veterans Health
COAG	Council of Australian Governments
CTAS	Career Transition Assistance Scheme
DCO	Defence Community Organisation
DESO	Directory of Ex-Service Organisations
DFRDB	Defence Force Retirement & Death Benefits Fund
DHSP	Deployment Health Surveillance Program
DIS-IV	Diagnostic Interview Schedule – 4 th Edition (Version IV)
DoD	Department of Defence
DSG	Defence Support Group
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4 th edition (Version IV)
DSO	Department Service Officers
DVA	Department of Veterans' Affairs
EDA	Extreme Disablement Adjustment
EMDR	Eye Movement Desensitisation and Reprocessing
ESO	Ex-Service Organisations
FaCHSIA	Families, Housing, Community Services and Indigenous Affairs (Department)
GARP (V)	Guide to the Assessment of Rates of Veterans' Pensions
GIP	Guaranteed Income Payment
GPs	General Practitioners
HMAS	Her Majesty's Australian Ship
HMCMP	High Needs Case Management Pilot
IPSS	Integrated People Support Strategy
IWB	Interdepartmental Working Group
LMOs	Local Medical Officers
MEC	Medical Employment Classification
MECRB	Medical Employment Classification Review Board
MRCA	<i>Military Rehabilitation and Compensation Act 2004</i>
MRCC	Military Rehabilitation and Compensation Commission
MRCG	Military Rehabilitation and Compensation Group
MSBS	Military Superannuation and Benefits Scheme
NSV	National Survey of Veterans

NVVRs	National Vietnam Veterans Readjustment Study
OSIs	Operational Stress Injuries
PCL	Posttraumatic Stress Disorder Checklist
PCL-C	Posttraumatic Stress Disorder Checklist – Civilian
PCL-M	Posttraumatic Stress Disorder Checklist - Military
PCL-S	Posttraumatic Stress Disorder Checklist – Non-military
PC-PTSD	Primary Care – Posttraumatic Stress Disorder
PDHA	Post-Deployment Health Assessment
PSS	Personnel Support Services
PTSD	Posttraumatic Stress Disorder
RAAF	Royal Australian Air Force
RCCS	Repatriation Comprehensive Care Scheme
RMA	Repatriation Medical Authority
RPBS	Repatriation Pharmaceutical Benefits Scheme
RPPS	Repatriation Private Patient Scheme
RSL	Returned and Services League of Australia
SCM	Symptom Cluster Method
SoPs	Statements of Principles (more than one)
SOS	Signs of Suicide
SPTSS	Screen for Posttraumatic Stress Syndrome
SPVA	Service Personnel and Veterans Agency
SRCA	<i>Safety Rehabilitation and Compensation Act 1988</i>
SRMR	Standardised Relative Mortality Ratio
SSRI	Selective Serotonin Reuptake Inhibitor
TAFE	Technical and Further Education
TFCBT	Trauma Focussed Cognitive Behavioural Therapy
TIP	Training and Information Program
TMS	Transition Management Service
TPI	Totally Permanently Incapacitated
TRIM	The Records Information Management - software
UK	United Kingdom
US	United States
VA	Veterans Affairs (USA)
VAC	Veterans Affairs Canada
VEA	<i>Veterans' Entitlements Act 1986</i>
VRAB	Veterans Review and Appeals Board
VRB	Veterans' Review Board
VVAA	Vietnam Veterans Association of Australia
VVCS	Veterans and Veterans Families Counselling Service
VVFA	Vietnam Veterans Federation of Australia
VVRS	Veterans' Vocation Rehabilitation Scheme
WWII	World War Two

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Executive Summary and Recommendations

EXECUTIVE SUMMARY

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 views 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 from 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 if 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.

RECOMMENDATIONS

PART A Suicide and suicide programs in veterans

Section 2 Overview of suicide and suicide prevention

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

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

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

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

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

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

Section 4 Rapid literature review of suicide prevention programs

No recommendations.

PART B Services for Australian Veterans with mental health problems

Section 5 Transition from the ADF

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

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

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

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

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

Section 6 Veteran compensation schemes and mental health

Recommendation 6.1: Initiatives such as the Single Claim Form, Separation Health Examination and the Client Liaison Unit are valuable and, subject to satisfactory trialing can be strongly supported.

The changing business processes of the MRCA group including a strong orientation to client-service are welcomed but should extend to all three schemes, particularly the VEA group and be further strengthened with business, training and evaluation plans.

Experienced case managers should be assigned to claims of clients having complex multiple needs claims.

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

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

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

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

Recommendation 6.5: In the event that a veteran’s claim is incomplete, DVA should consider a further step in the primary application process whereby the application could be returned to

the veteran indicating areas where further supporting documentation is the necessary. This would be different in nature to a Section 31 review.

Section 7 PTSD and compensation

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

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

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

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

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

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

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

Both groups would be subject to appropriate quality assurance procedures.

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

Section 9 Mental health programs and services for veterans

Recommendation 9.1: DVA's mental health strategy beginning in 2001 has led to the development of a number of community mental health promotion programs. DVA intention to consider how this strategy might be further developed is strongly supported. Programs for suicide and alcohol misuse require particular attention. *The ACPMH have been contracted by DVA to evaluate its Mental Health Initiatives for 2007-10 and this will be very useful in identifying other areas.*

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

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

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

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

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

Section 1 Introduction

1.1 Terms of Reference

Background

1 An election Commitment in Labor's Plan for Veterans' Affairs is to conduct an independent study into suicide in the ex-service community.

Purpose of the Study

2 The suicide study will examine the broad issues of suicide in the ex-service community, and a number of specific cases of suicide in the last three years, to help identify:

- ex-service members who are at increased risk of self-harm;
- common contributing factors among ex-service members who have committed or attempted suicide;
- the extent of suicide in the ex-service community;
- lifestyle or other factors that may be contributing to suicide in the ex-service community; and
- recommended administrative reforms or initiatives to help combat suicide in the ex-service community.

Structure of the Study

3 An eminent person will be appointed to conduct the study. That person will be supported by a secretariat from the Department of Veterans' Affairs (DVA) and will have the capacity to draw on appropriate experts as required.

Timing

4 It is expected that a report on the study will be provided to the Minister for Veterans' Affairs in December 2008.

Issues for Consideration

5 The study should be cognisant of a number of election commitments already identified by the Government to address mental health issues. These include (but are not limited to):

- (a) The ADF mental health 'Lifecycle' package;
- (b) Applied Suicide Intervention and Skills Training (ASIST) program; and
- (c) Make community mental health care ex-service friendly.

6 The study should take into account the work from the Inter-Departmental Working Group looking at rationalising the administrative burden for veterans dealing with multiple agencies and the transitional arrangements.

7 The study should draw on investigations into individual suicides, including Boards/Commissions of Inquiry (for example the recent Gregg Review), to examine the recommendations, the subsequent responses and action taken.

The study should draw on other reviews that have occurred or are occurring relevant to suicide or at risk behaviours in the ex-service community. These include (but are not limited to):

- (a) Relevant research such as the “Preventing suicide: a psychological autopsy study of the last contact with a health professional before suicide” that is currently being undertaken by Griffith university; and
- (b) The imminent Australian Institute of Health and Welfare investigation into the cause of death of DVA clients by age/sex/conflict with a specific focus on suicide.

9 The Study should also consider any relevant information that is made available to the concurrent Review of Mental Health Care in the Australian Defence Force (ADF) and Transition through Discharge.

Terms of Reference

10 The specific tasks of the study are to:

- (a) Review recent cases of suicide, including those previously identified by the National Veterans’ Mental Health and Wellbeing Forum;
- (b) Draw on current national and international research and literature reviews to identify common contributing factors among ex-service members who have committed or attempted suicide;
- (c) Identify lifestyle or other factors that may be contributing to suicide in the ex-service community;
- (d) Identify indicators that could help identify ex-service members who are at an increased risk of self harm;
- (e) Having regard to the Review of Mental Health Care in the ADF and Transition through Discharge, help address suicide in the ex-service community, including highlighting changes to current policies, procedures and practices that exist in DVA that would minimise potential stress
- (f) Estimate the extent of suicide in the ex-service community, compared to the general community; and
- (g) Prepare a final report to the Minister of Veterans’ Affairs by December 2008 with appropriate findings and recommendations.

Governance Board

11 A governance board will be set up to oversight the study and provide advice to the Department on the progress of the study.

1.2 Methodological approach

PART A Suicide and suicide programs in veterans

An extended narrative literature review on suicide and its risk factors in veterans was conducted – see Section 3.

DVA medical and compensation files and, where relevant VVCS files were read for the six veterans who had recently committed suicide, identified by the Veterans Mental Health and Wellbeing Forum for the attention of this study (following approval by DVA’s Ethics Committee). Telephone calls were made with relatives of some of these veterans who expressed willingness to doing so.

The three reports on the review of the suicide of Signaller Geoffrey Gregg have also been read:

- Part 1 Mr Geoff Earley Inspector-General ADF Independent review of Department of Defence processes.
- Part 2 Mr Christopher Doogan Investigation/Inquiry report for the Department of Veterans Affairs and ComSuper relating to their dealings with the late Mr Geoffrey Gregg.
- Part 3 Mr Ronald McLeod Review of Commonwealth agencies relationship with the late Signaller Geoffrey Gregg.

The events leading up to the suicide of the six veterans were very important in providing insight and in framing several of the recommendations particularly in the PART B chapters. For ethical reasons however it is not possible to describe or discuss the details of these individuals or the events impacting on them.

Public submissions from individuals and groups proceeded at the same time as these consultations and rapid literature reviews were being conducted. 42 submissions were received of which 77% were from individuals and 23% from groups. These were analysed in relation to the emergent themes noted above and are summarised in Appendix 1 Emergent themes from public submissions to the Independent study into suicide in the ex-service community. The views expressed in these themes are those of the individuals and groups who made these submissions and do not reflect the views of the author.

Submissions cover both PART A and B issues

PART B Services for Australian Veterans with mental health problems

Part B chapters move beyond consideration of suicide to explore mental health problems and mental health services in veterans more generally. They also consider the policies and programs of DVA and the experience of veterans with these policies and programs. This is required under the Terms of Reference of the Study. It is also essential to better understand the suicide experience of veterans.

This part of the Study proceeded through very extensive consultations and interviews with:

- senior members of Veterans Affairs including those with involvement in the organisation and delivery of mental health and compensation schemes:
- representatives of Ex-Service Organisations (ESOs);
- members of ADF and senior members of Defence.

Visits were also made to eight military bases which typically involved a series of meetings with the Commanding Officer, other senior staff, as well as senior health staff, junior Officers, Non Commissioned Officers and Other ranks.

Extensive notes were taken at these meetings and these were used to generate a number of emergent themes. These themes were used to assemble the relevant literature relevant to these themes. This involved accessing the peer-reviewed research literature principally using Medline, as well as the so-called 'grey' on the internet-based research and other materials not published in peer-reviewed journals.

These themes in turn were subjected to seven rapid literature reviews. These are set out below. Time constraints meant their main purpose was not to draw definitive conclusions. Rather they were to scope the literature to identify main key papers and systematic review and summarise the most important points that their authors were making. Time constraints meant that no new research studies to fill important gaps in the literature were possible.

Section 4	Rapid literature review of suicide prevention programs (in PART A)
Appendix 2	Rapid literature review of PTSD and best-practice treatment.
Appendix 3	Rapid literature review of Adjustment disorders and best-practice treatment.
Appendix 4	Rapid literature review of combat exposure and Post Traumatic Stress Disorder.
Appendix 5	Rapid literature review of barriers to mental health care in the ex-service community including stigma.
Appendix 6	Rapid literature review of mental health promotion and literacy. programs
Appendix 7	Rapid literature review of interventions to reduce alcohol misuse.

A very extensive file of DVA and ADF technical documents and analyses were also made available, including some requested by me.

After a data reduction exercise, a narrative was generated from all these data sources within each of the emergent themes that seemed to best capture the totality of the presented material. This is presented in the following chapters, a chapter devoted to a particular theme. Inevitably it was necessary to make acts of judgement as the information presented was not always complete and sometimes was contradictory. It is also impossible to avoid all value judgements in doing this.

Part A Suicide and suicide programs in veterans

Section 2 Overview of suicide and suicide prevention

2.1 Introduction

While Part A considers suicide and suicide prevention programs in veterans in Australia, Part B considers services for Australian veterans with mental health problems,

A review of the research literature on suicide and its risk factors in veterans is presented in Section 3. A rapid literature review on suicide prevention programs is set out in Section 4. This section (Section 2) provides an overview of both Sections 3 and 4. It also describes Operation *Life*, DVA's suicide prevention framework and considers the implications of all available evidence for DVA suicide prevention programs.

Any possible effects of DVA policies and practices on veterans who subsequently committed suicide are considered more in Part B. These were based on a review of all technical and research documents, stakeholder input and public submissions.

They were also based on a review of the six suicides of recent veterans identified by the Veterans Mental Health and Wellbeing Forum for the attention of this study. This involved a careful and detailed reading of DVA medical and compensation files and VVCS files, where relevant. This followed advice from DVA that approval from the DVA Ethics Committee was not necessary. Telephone calls were also made with relatives of some of these veterans who expressed willingness to do so. The three reports on the review of the suicide of Signaller Geoffrey Gregg were also read.

The events leading up to the suicide of these six veterans were very important in providing insight and in framing several of the recommendations particularly in the PART B chapters. For ethical reasons however it is not possible to describe or discuss the details of these individuals or the events impacting on them.

2.2 Conclusions of the literature review on suicide in veterans

The aim of this review was 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.

As background the review noted that 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.

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 demonstrated among the general population, some such as availability of firearms and exposure to combat are specific to veterans and may form the basis of preventative activity.

The Australian Institute of Health and Welfare investigation into the cause of death of DVA clients by age/sex/conflict with a specific focus on suicide is well-advanced but not complete. Its results will be separately released.

2.3 Evidence-based suicide prevention programs

The rapid literature review of suicide prevention programs came to a number of conclusions. These were that while the evidence-base for the relative effectiveness of suicide prevention approaches is not extensive, there were sufficient numbers of recurrent themes to envisage what the key features of a successful intervention might be. These were:

- Embedding the suicide prevention program within a broad-based community education, treatment and support service that minimises stigmatisation.
- Delivery of the following core program components:
 - 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;
 - appropriate medication regimes.

2.4 Operation Life

The National Suicide Prevention Strategy for the veteran community - 'Operation Life' links closely to the *National Suicide Prevention Strategy* and the *Living Is For Everyone (LIFE)* Framework. This framework aims to improve understanding of suicide, raise awareness of appropriate ways of responding to people considering taking their own life and raise awareness of the role people can play in reducing loss of life to suicide.

Operation *Life* provides a framework for action to prevent suicide and promote mental health and resilience across the veteran and DVA communities.¹ It has five priority areas:

¹ The Australian Government Mental health & well being Operation *Life*
(<http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/operation-life-1> - accessed 23 Jn 2009)

1. promote resilience, mental health and well-being across the veteran community through education, training and self- awareness;
2. enhance protective factors by reducing risk factors for suicide and self-harm within the veteran community eg: The Right Mix - your health and alcohol, staff mental health literacy training and ready access to health providers;
3. deliver support through the VVCS and allied health services for veterans and their families at increased risk of suicide;
4. develop partnerships with the veteran and ex-service community through such areas as the men's health peer education facilitators and TIP trainers; and
5. research the evidence base for suicide prevention and good practice through such projects as 'Ageing and psychological symptoms in the elderly veteran'.

Four workshops have been available free of charge for the veteran community.

- safeTALK (2 hours – now discontinued) is a workshop designed to alert communities to the signs that someone may be considering suicide;
- suicideTALK (4 hours) is a workshop designed to encourage participants to create suicide-safer communities;
- ProgramASIST is a 2-day skills based workshop that aims to increase the capacity of the veteran community to recognise and support members of their community at risk of suicide, and help those at imminent risk to stay safe & seek further help;
- ASIST TuneUP is a workshop that consolidates and refines the learning from ASIST and examines how it is applied in the real world.

Operation *Life* has evolved as a framework. Suicide prevention was identified in DVA's Mental Health Policy and Strategic Directions paper *Towards Better Mental Health for the Veteran Community* of 2001' as a contribution by DVA to the National Mental Health Strategy.² It began as Project ASIST (Applied Suicide Intervention Skills Training) with Vietnam Veterans under ESO auspice. It was conducted by LivingWorks and Lifeline Australia. It broadened its activities to become ProgramASIST in 2004. It has targeted veterans with PTSD and mental health problems and their families. Key individuals, ESOs, DVA and VVCS have been involved in its funding, development, administration and promotion. It became Operation *Life* in 2007 and received further major funding from the incoming Labor Government. The additional funding will cover not only expenses associated with attendance but also development of a new web-based resources directed at veterans, their families and health providers.

Some difficulties have been reported in program delivery in the past concerning uneven rollout and uncertain takeup.

While Operation *Life* and its precursors have not been evaluated by DVA, ASIST programs, more generally have been evaluated in several countries. ASIST (Applied Suicide Intervention Skills Training) is a two-day training program developed at the University of Calgary and marketed internationally by LivingWorks Education. ASIST is targeted at professional and lay caregivers, training them to recognise suicide risk and apply appropriate

² Department of Veterans' Affairs Mental Health Policy and Strategic Directions paper 'Towards Better Mental Health for the Veteran Community (<http://www.dva.gov.au/health/younger/mhealth/policy/pdfs/mhpolicy.pdf> - accessed 24 Jan 2009)

risk reduction methods. Numerous evaluations of the program's effectiveness in terms of learning outcomes have been undertaken (LivingWorks Education 2007)³.

One is included here for illustrative purposes. The study of ASIST in Scotland by Griesbach et al (2008) used data from: the national ASIST database; a survey of 534 former course participants from the years 2003-2007; and interviews or focus groups with a sub-sample of 22 former participants, 28 ASIST trainers, and 19 key stakeholders.(Griesbach, Dolev et al. 2008). Course participants reported considerable increases in their knowledge, skills and confidence as a result of their ASIST training, as would be expected from an internationally recognised program. Follow-up data suggested that participants were more likely to intervene with persons at risk of suicide after their training than prior to training. Some respondents credited the ASIST program with reducing the stigma associated with suicide, and raising awareness in communities. The evaluation did not assess the impact of ASIST on rates for attempted or completed suicides, citing barriers including: the unreliable reporting of suicidal acts; the likely time lag between intervention and effect; and the critical mass of program trainees required to achieve measurable effects.

It is appropriate therefore that DVA has recently retendered Operation *Life* and specified a wider focus set out in the five priority areas above. Courses will remain at 2-day for TIP trainers, Pension officers and DVA staff members and move to 4-5 hours for veterans and their families.

2.5 Assessment and recommendation

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.

Recommendation 2.1: In considering the wider focus for Operation *Life* expressed in the five priority areas, DVA should closely considers the evidence-based literature on suicide prevention and should only implement programs that are evidence-based and most likely to

³ See Section 9 for references.

be successful in veterans. These are most importantly doctor education on detection and treatment of depression and restricting access to lethal means.

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

3.1 Summary

Background: 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.

Methods: A literature search using key words related to veterans and suicide was conducted. The following databases were searched: Medline 1996-2008 and Scopus 1998-2008. Grey literature was searched using Google and other key documents as recommended by experts in the field were also included.

Results: 127 peer reviewed articles were retrieved. 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 however the evidence is by no means conclusive. Whilst US based studies mostly indicate elevated suicide rates among veterans, the data from other countries are also largely inconclusive.

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.

Conclusions: 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.

3.2 Background

Suicide is complex in its definition and causation. It is generally defined as an intentional death of an individual due to either an active act of commission or passive act of omission. (Maris, 2002).

The World Health Organisation’s International Classification of Diseases model ICD-10 has suicide listed under external causes of morbidity and mortality, listing under x70-x84 a number of categories of intentional self-harm. Each category refers to the method by which suicide was achieved. Methods of suicide vary from one country to the next but in Australia, hanging is the most common method followed by gassing, poisoning by drugs, contact with sharp objects, falls, firearms and drowning.

The term ‘parasuicide’ has been used when there is a deliberate attempt to self-harm, with or without clear intention to die, although the term is decreasing in usage, replaced by ‘deliberate self-harm’. Nevertheless suicide can be considered on a continuum from suicidal ideation to gestures, suicide plans, attempts and through to completed suicide.

Generally suicide rates are lower in serving military groups than in the general population due to ‘healthy worker’ selection effects. However the ‘healthy worker’ 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. International research, mainly from the US, suggests that suicide rates among the ex-service community are higher than those in the general population however there is more limited research into suicide among the ex-service community in Australia.

This review examines both the rates of, and risk factors for suicide in the general and ex-service populations in Australia and overseas.

3.3 Method

A number of search engines were used with key words related to veterans and suicide (see Table 1). Grey literature was also searched using Google, with the key words of veterans and suicide. These results were supplemented with key documents recommended by experts in the field.

Table 1: Searches undertaken to find articles on suicide and veterans

Search engine	Years searched	Key words searched	Result
Medline	1996 – 2008	Suicide exp (statistics and numerical data, trends) combined with Veterans or Mesh	19 articles
Medline	1996-2008	Suicide (classification, prevention and control, statistics and numerical data, trends) and war/ pr veterans	70 articles
Scopus	1998 – 2008	Suicide and veterans in health sciences literature, including medical, nursing, multidisciplinary, dental health, arts, business decisions, economics, psychology, sociology	38 articles

3.4 Results

In total 127 journal articles were retrieved.

Rates of suicide in the general population in Australia

Although suicide is a relatively uncommon event - it is one of the leading causes of external death in Australia with substantial human and economic costs. In 2006 (the year for which most recent data are available) there were 1,799 deaths from suicide registered in Australia). Approximately three-quarters of suicide deaths were males and one quarter were females (1,398 and 401 respectively). The age-standardised suicide rate was 8.7 per 100,000 (Australian Bureau of Statistics, 2008).

Table 2: Age-specific suicide rates (no. of suicides per 100,000 pop) Australia, 2006

Age grp	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+	All ages
M	8.8	16.8	15.0	17.2	21.5	18.8	22.0	18.7	15.7	15.1	11.7	16.5	16.7	13.9	34.5	13.6
F	3.5	4.2	3.9	4.1	6.0	5.3	4.2	6.0	6.0	4.7	3.0	6.1	4.7	5.0	4.1	3.9
All	6.2	10.6	9.5	10.6	13.7	12.0	13.0	12.3	10.9	9.9	7.3	11.1	10.2	8.6	14.0	8.7

Source: Australian Bureau of Statistics (2008).

High risk groups

The risk factors for suicide have been summarised in the *LIFE* Framework which is the overarching framework for suicide prevention in Australia (Living is For Everyone Framework, 2007). There are some groups in particular who are at elevated risk of suicide, most notably people who have made a previous suicide attempt, people who have expressed suicidal ideation and people with a mental illness. Men, in particular unmarried men generally have higher suicide rates than women. Other high risk groups include Indigenous Australians and people who have been bereaved by suicide.

Suicide rates also vary by location within Australia. Between 2001 and 2005 the highest suicides rates were seen in the Northern Territory, followed by Tasmania, Queensland and South Australia, all of who had suicide rates above the national average. New South Wales, Victoria and the ACT all had rates below the national average (ABS, 2008 - 3309.0 - Suicides, Australia, 2005). In general there are higher suicide rates in rural compared with metropolitan areas and men aged 20-29 in non-metropolitan areas have particularly high suicide rates (Caldwell et al, 2004).

Trends over time in suicide rates

Suicide rates in the general population have been changing over time both in Australia and in many other Western countries. In Australia the suicide rate has decreased since its peak in 1997; in 2006 the age-standardised suicide rate was 8.7 per 100,000 compared to a rate of 14.7 per 100,000 in 1997 (Australian Bureau of Statistics, 2008). Similar decreases were seen in the United States where the rate fell from 13.2 in 1995 to 10.3 in 2001 and in the United Kingdom where the rate fell from 21.0 in 1991 to 17.4 in 2006 (Office for National Statistics, 2007).

The debate as to the reasons for these reductions is inconclusive. The pathways to suicide are complex and multi-factorial and therefore strategies to reduce rates of suicide are necessarily varied. However Goldney (2006) has suggested that reduced suicide rates in Australia could be a result of better community awareness of suicide prevention, programs promoting better recognition of depression and programs promoting the treatment of depression. Morrell et al (2007) argue that the national Youth Suicide Prevention Strategy implemented during 1995-1999 may have influenced the decline whilst Hall et al (2003) have suggested that increasing rates of antidepressant prescription is helping to prevent suicide.

Summary facts: suicide in the general Australian population

The following information on suicide in the total Australian population is provided here as a reference point for the discussion below on suicide in veterans (Australian Bureau of Statistics, 2008).

In 2006, 1.3% of all Australian deaths registered were attributed to suicide.

- There were 1799 deaths from suicide registered in 2006.
- The age-standardised suicide rate (for persons) in 2006 was 1.6% lower than the corresponding rate for 2005 and 41% lower than the peak occurring in 1997.
- The age-standardised suicide rate for total males (13.6 per 100 000) in 2006 was lower than in any year in more than a decade (1995-2006).
- The age standardised suicide rate for total females (3.9 per 100 000) in 2006 was also lower than in any year in more than a decade (1995-2006).
- The highest age-specific suicide death rate for males in 2006 was observed in the 85 years and over age group (35 per 100 000) and the lowest was in the 15-19 years age group (8.8 per 100 000).
- In 2006, the most common method of suicide was hanging, which was used in around half (52%) of all suicide deaths.

The figures above refer to completed suicides. However because statistically suicide is classed as a relatively uncommon event, and because suicide attempt and suicidal ideation are the strongest predictors of completed suicide, it is not uncommon to use these as proxy indicators of suicide risk. Therefore, when considering the problem of suicide and those who may be at risk it can also be helpful to look at rates and risk factors for suicide attempt and suicidal ideation.

It is difficult to estimate the rates of suicidal ideation, but Pirkis et al (2000) reported that 3.4% of people surveyed in the Australian National Survey of Mental Health and Wellbeing reported suicidal ideation in the previous 12 months. In the same study, the rate of non-fatal suicide attempts was 0.4%.

Rates of suicide among veterans

People recruited into the armed forces are subject to physical and mental health screens and are therefore a healthy sub-group of the total population; rates of both physical and mental health disorders would be expected to be lower than among the rest of the population. This healthy worker effect may however be counter-balanced by the deleterious effects of exposures encountered during armed service, so that veterans who have completed armed

service could end up being in poorer health compared with the rest of the population, as studies described below make clear.

The morbidity and mortality of veterans has been studied in considerable detail, and many studies have included suicide rates in health indicators. While more studies have been undertaken examining the physical health of veterans, increasingly mental health is also being investigated, with a particular focus on whether any mental disorders found in veterans can be attributed to their experiences of war or active deployment. Veterans of a number of major deployments since World War II have been studied, but the Vietnam War has received the most attention. Veterans in the United States have been studied in much greater detail than those elsewhere.

It is probably worth noting two caveats when examining rates of suicide among veterans. The first relates to the point above and concerns the issue of a comparison group. Some studies have compared suicide rates among veterans with rates in the general population; however because of a possible healthy worker effect (as well as other socio-demographic factors that may place people at increased or decreased risk of suicide) this is not necessarily straightforward. Other studies have compared veterans who were engaged in active combat with those who were not. Thus there is some inconsistency regarding the comparison groups employed. A further caveat is that some studies report standardised mortality rates whilst others report relative risk ratios which can be confusing when interpreting the data.

Studies of suicide among Australian veterans

There have been a number of studies examining suicide in the Australian ex-service community. These include a series of government commissioned studies of health and mortality, including suicide, in Australian Vietnam veterans which are summarised below.

The Morbidity of Vietnam Veterans: A study of the health of Australia's Vietnam veteran community: This study conducted by the Australian Institute for Health and Welfare (AIHW, 1999) involved a series of studies into the health of Vietnam Army veterans and their families and included a retrospective cohort study of mortality in 46,166 Australian national servicemen. This study compared the mortality of national service veterans who served in Vietnam to national service personnel who remained in Australia. This study found no significant increase in mortality among veterans who served in Vietnam compared to those who did not and both groups demonstrated significantly lower mortality rates than expected for a similar aged cohort of Australian males.

However despite the relatively low rates of mortality among veterans reported by this study, the children of the veterans studied were reported to have above average rates of death: Veterans were asked to report on deaths in their children according to three categories of cause: accident/other, illness and suicide. This study conducted an extensive validation exercise and found that, after the data were validated, children's death rates as reported by their veteran fathers were above those expected based on Australian community standards in all three categories, and in particular their rate of suicide was three times higher than that of the general population. See Table 3 over.

The Mortality of Vietnam Veterans Study: This study (Crane et al, 1997a) examined mortality in all three service branches – the Army the Air Force and the Navy. The mortality rate for all male military personnel and individual Service branches was compared to the

mortality rate for the general male Australian population between the years 1980 to 1994. Both the overall mortality rate (SMR = 1.07; CI 1.02, 1.12) and the suicide rates (SMR = 1.21; CI 1.02, 1.42) were found to be significantly higher among ex-military personnel than among the general population. Among the individual Service branches, Navy veterans had the highest mortality rate, elevated by 37%, with significant elevations in mortality from external causes, including suicide. Army and Air Force veterans did not demonstrate a significantly different overall mortality rate from the rest of the Australian population.

However the Standardised Relative Mortality Ratio (SRMR) for suicide was not raised (114; 95 CI% 77-133). SRMRs are used principally to identify a factor or component that may suggest the reason for the elevated SMR. This was not relevant for suicide and the SRMR should be disregarded and the SMR of 1.21; CI 1.02, 1.42 should be regarded as correct.

Table 3: Number of veterans' children's deaths by validation status

Condition	Validated	Not validated	Not able to be validated	Estimated validated	Expected validated (confidence interval)
Died due to accident / other	219	43	528	660	365 (328-402)
Died due to illness	504	33	469	944	805 (749-861)
Died from suicide	111	4	12	230	75 (58-92)
Total	834	80	1,120	1,834	-

Source: From AIHW, 1999.

Mortality of National Service Vietnam Veterans study: This was a supplementary study (Crane et al, 1997b) to the previous Vietnam Veterans Study, extending the period of data collection by a further seven years, and was undertaken specifically to compare mortality rates among national service veterans who saw combat in Vietnam with those who did not. The study had a follow-up period of between 22 and 29 years. The mortality rate from all causes was slightly higher in veterans who served in Vietnam (relative risk = 1.28; CI 0.97, 1.70) however suicide rates were not significantly elevated (relative risk = 1.13; CI 0.77, 1.67).

The Third Australian Vietnam Veterans Study (Wilson et al, 2005) is a retrospective cohort study of male Australian personnel who served in Vietnam between May 1962 and July 1973. The study examined all deaths identified during the period from completion of Vietnam service to 31 December 2001 and compares the mortality rates of male Australian Vietnam veterans with those of Australian males in the general population. Overall, Australia's veterans of the Vietnam War displayed lower rates of mortality than the general population and although suicide was among the more common causes of death in this population the rate was no higher than that of the general population (See Table 4 over).

Table 4: SMRs for a priori causes of death, Vietnam War Australian veteran cohort

Cause of death	Number of deaths	SMR	95% CI
All causes	6166	0.94	0.92,0.97
Infectious diseases (excluding AIDS)	33	0.62	0.41,0.83
Neoplasms	2058	1.06	1.02,1.11
Ischaemic heart disease	1297	0.94	0.89,0.99
Chronic obstructive pulmonary disease	128	0.85	0.70,1.00
Digestive diseases	292	1.03	0.91,1.15
Alcoholic liver disease	161	1.19	1.01,1.38
Neurological diseases	91	0.78	0.362,0.94
Motor neurone disease	25	1.06	0.64,1.47
Suicide	421	1.03	0.93,1.13
Motor vehicle accidents	553	1.03	0.95,1.12

Source: Wilson et al (2005)

The healthy worker effect, i.e. the selection of men who were fit at the time of service, at least in part, was thought to account for this overall lower mortality. However the manifestation of the healthy worker effect diminishes over time and when the follow-up period was broken down into three distinct time periods the mortality rate for some causes of death, including suicide increased (See Table 4).

Table 5: Change in suicide rates over time for all Vietnam veterans

1963-1979				1980-1990				1991-2001			
Observed	Expected	SMR	95%CI	Observed	Expected	SMR	95%CI	Observed	Expected	SMR	95%CI
112	130	0.86	0.70–1.02	150	142	1.06	0.89–1.23	159	139	1.15	0.97–1.33

Source: Adapted from Wilson et al, 2005.

A further study of Australian Vietnam era draftees was conducted by O’Toole et al (1996). This study examined 1,000 army veterans whose service had been completed more than 20 years previously. Whilst this study did not examine suicide or mortality specifically, it did identify veterans to be at increased risk of health problems which may lead to elevated mortality, when compared to community norms. The conditions mainly affecting the Australian veterans were alcohol abuse or dependence, post-traumatic stress disorder and somatisation disorder. These were found to be significantly related to combat exposure but not with posting to a combat unit. The authors concluded that veterans are at risk of a range of psychological health problems which may last for as many as twenty years post exposure to combat.

The Korean War has received less attention in the Australian literature. However a study conducted by Harrex et al (2003) of Korean War Australian veterans did find an elevated suicide rate. Overall, Korean veterans had a 21% higher mortality rate than an equivalent Australian male population the death rate from suicides was elevated by 31% (See Table 4). However this varied for the Army, Navy and Air Force. Army veterans had a 53% higher suicide rate than the general Australian male population but there did not appear to be elevated suicide rates in the other forces. Those who completed their service by 1952 (which marked the end of the offensive/counter offensive phase of the conflict) had a significantly lower suicide rate than the general population whilst those who served in Korea after 1952 had a higher suicide rate than the general population.

Almost 9% of Korean War veterans had also participated in the Vietnam War, and at least 30% of Korean War veterans also participated in World War II. The impact of this upon suicide rates is unclear.

Table 5: Significantly elevated causes of death for all Korean War Australian veterans

Cause of death	N deaths	SMR (unknowns excluded)	95% CI
All cases	7514	1.21	1.18-1.24
Circulator disease	2894	1.13	1.09-1.17
Ischaemic heart disease	1951	1.10	1.05-1.15
Stroke	451	1.17	1.06-1.28
Neoplasms	2476	1.31	1.26-1.36
Respiratory disease	573	1.32	1.21-1.42
Chronic obstructive pulmonary disease	362	1.49	1.33-1.64
Respiratory excluding COPD	164	1.45	1.23-1.67
Digestive disease	306	1.35	1.20-1.50
Liver, gallbladder, bile ducts	186	1.33	1.14-1.52
Alcoholic liver disease	109	1.36	1.11-1.62
External causes	814	1.37	1.28-1.47
suicide	211	1.31	1.14-1.49

Source: Harrex et al (2003)

The Australian Gulf War Veterans Health Study (Sim et al, 2003) compared the health and mortality of Gulf War veterans from all three service divisions, with that of a random sample of members of the Australian Defence Force (ADF) who were eligible to be deployed to the Gulf War, but who were not deployed. Deaths between the years 1991 and 2000 were included. The mortality rates from all external causes, including intentional self harm were found to be similar in the two groups; of the deaths due to external causes, one-third were due to intentional self harm in both groups. However the authors advise exercising caution when interpreting these results as the numbers of deaths were small.

This study also examined additional health outcomes and found Gulf War veterans to be at greater risk of developing psychological disorders and to have persisting psychological symptomatology than the comparison group, which could place them at increased risk of suicide in the future.

Studies of suicide among overseas veterans

Whether or not studies of overseas ex-service communities generalise to those in Australia is difficult to determine with any certainty. Further, it is difficult to interpret international comparisons with Australia because of different methods of ascertaining suicide rates. As noted above the overseas literature regarding suicide in veterans has been dominated by studies conducted in the US, most of which have concluded that the suicide rate is higher among veterans. However this is not necessarily the case in studies conducted in other countries.

Kaplan et al (2006) used data from the National Health Interview Survey to estimate the risk of mortality from suicide among American male veterans. Their sample included 104,026 veterans and 216,864 non-veterans and they found that over a 12 year period, veterans were

twice as likely to die of suicide compared with male non-veterans in the civilian population. The risk of death from natural or external causes (accidents and homicides) did not differ between veterans and non-veterans after adjusting for confounding factors. The study did not examine factors that may have increased the risk of suicide, such as psychiatric conditions, although other studies have looked at this in detail (for example Zivin et al, 2007).

The US Veterans Health Study (Zivin et al, 2007) studied 807,694 veterans and concluded that veterans may be particularly susceptible to suicide because of the high prevalence of depressive disorder and co-morbid psychiatric conditions among this population. According to this study the prevalence of depressive symptoms among veterans was two to five times higher than among the general US population, and that overall the suicide rates among the depressed veteran population were seven to eight times higher than among the general population with a rate of 13.5 in the general population compared to 88.25 in the veteran population.

A study by Kang & Bullman (2008) also in the US, reported that the rate of suicide among veterans from the conflict in Iraq was no different to that of the general US population at that time. However they did suggest that there may be vulnerable subgroups for whom suicide risk may be elevated; these include active component service members and servicemen with mental disorders. Previous studies of Vietnam veterans conducted by the same authors (Bullman & Kang, 1994; 1996) have also suggested that risk of suicide could be elevated among veterans who experienced severe physical or psychological trauma during war.

A detailed investigation conducted by CBS news (2007) found that in the year 2005 American veterans were more than twice as likely to commit suicide as non-veterans; rates were between 18.7 to 20.8 per 100,000, and 8.9 per 100,000 respectively.⁴

MacFarlane et al (2000) found that in a retrospective cohort study of all UK armed forces who served in the Gulf War between September 1990 and June 1991, suicide rates were no different in the Gulf veterans compared with a cohort of people in military service who had not served in the Gulf war. They did however report a slightly higher rate of 'external' (i.e. accidental) causes of death among those who had served in the Gulf.

A study of Norwegian peacekeepers (Thoresen et al, 2003) found elevated suicide rates among 22,275 veterans studied. The standardised mortality ratio was highest in veterans who were more than ten years away from their peacekeeping service. Fifty five per cent of suicides occurred with firearms. However the authors attributed their results to a selection effect. Former peacekeepers were less frequently married than would be expected in the general population (a known risk factor for suicide) and when marital status was taken into account the elevated suicide risk disappeared.

In summary, while Australian veterans have not been studied as extensively as overseas veterans the studies that have been undertaken have shown some evidence indicating elevated suicide rates among Australian veterans compared to the general population however the evidence is by no means conclusive. Whilst US based studies mostly indicate elevated suicide rates among veterans, the data from other countries are also largely inconclusive. Some of the studies cited above have suggested that elevated suicide rates may be the result of risk factors, some of which are similar to those affecting the general population such as

⁴ http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml

psychiatric disorder and marital status, whilst others are specific to the veteran population, such as exposure to combat. A more detailed discussion of the risk factors associated with suicide risk among the general population and among veterans is included below.

Risk factors for suicide in the general population

When considering risk factors that may contribute to suicide in the ex-service community, it is worth considering the causes of suicide in the general population. These risk factors can be weighed against any healthy worker effect or other biases due to recruiting into the armed forces, as well as the impact of specific exposures as a result of service in the armed forces. The pathways to suicide are complex and multi-factorial and studies examining risk factors are often hampered by small sample sizes and varying definitions of suicide risk. Further suicide is a low base rate event and many of the risk factors for suicide lack both specificity and sensitivity and thus have relatively poor predictive value. For example, it can be seen below that being male and or being unemployed are classed as risk factors for suicide; whilst this is certainly the case it is also true to say that most males and most unemployed people do not commit suicide. However that said research has led to some evidence regarding risk factors for suicide that can be of use when planning prevention strategies. This evidence has been classified by DeLeo & Krysiniska (2007) who have provided a detailed assessment of the strength of evidence for risk factors associated with suicide in the general population:

Level A evidence is strong evidence with conclusive results and includes:

- Demographic factors – males aged 30-34, Indigenous, rural and remote populations
- Psychopathology & psychiatric hospitalisation – diagnosis of a mental disorder, particularly affective disorders, substance abuse, anxiety disorders, personality disorders and psychiatric comorbidity
- Previous non-fatal suicidal behaviour and suicidal ideation
- Family history of psychopathology and suicidal behaviour
- Physical illness, chronic physical pain
- Negative life events and low coping potential
- Marital status of divorced, widowed or separated;
- Low socioeconomic status, unemployment
- Neurobiological activity – hypo-activity of the serotonergic system
- Psychological factors – hopelessness; high aggression and impulsivity, lack of reasons for living, cognitive rigidity, low ability to solve problems, perfectionism, psychological pain
- Social isolation and lack of social support
- Easy access to and availability of lethal means of suicide
- Inappropriate media reporting

Level B evidence is good evidence with reasonably conclusive results and includes:

- Self-mutilation

Level C evidence is where there is some evidence but more research is needed in the area:

- Religion; lack of sanctions against suicide
- Migration – high suicide rates in country of origin, acculturation stress, social isolation, language barriers
- Neurobiological factors

Level D evidence links a particular risk factor to suicidal ideation and/or non-fatal suicidal behaviour however more research is required in order to establish a relationship with completed suicide. This includes:

- Aborted suicide attempts
- Sexual orientation – homosexual orientation

It is expected that these risk factors will also apply to the veteran population. However there may be additional risk factors specific to this population, or particular combinations of risk factors that make veterans particularly susceptible to suicide.

Risk factors for suicide among veterans

Risk factors for suicide among veterans are classified into socio-demographic factors, psychiatric and psychological factors, access to and availability of means of suicide and exposure to combat.

Socio-demographic factors

As in the general population there are several demographic factors that appear to be associated with elevated suicide risk. In particular male veterans have been found to have higher suicide rates than females (Zivin et al, 2007). This study reported rates of 89.6 per 100,000 and 28.9 per 100,000 for men and women respectively. The same study reported that non-Hispanic white veterans had higher rates of suicide compared with Hispanic veterans or African American veterans and that younger veterans had higher suicide rates than older veterans – veterans aged between 18 and 44 committed suicide at a rate of approximately 95 per 100,000 compared with 78 per 100,000 for veterans aged 45-64 years and 90 per 100,000 for those aged 65 and older.

Lambert & Fowler (1997) conducted a review of suicide risk factors in the veteran population and also found male gender to be associated with increased risk of suicide, by a ratio of about three to one. Whilst women may make more frequent suicide attempts and may engage in more frequent self-injurious behaviour (itself a risk factor for completed suicide), completed suicide is more common in men. The authors also suggest that poor psychosocial support is a risk factor for suicide, citing an inadequate family income, lack of marital support and lack of a stable place to live as examples of this.

However, unlike the study by Zivin et al (2007) Lambert & Fowler (1997) found men over the age of sixty-five to be at increased risk, and they suggest that as the veteran population ages, suicide risk will increase postulating that older veterans fit the profile of those most at risk of suicide, citing poor health, diminished psychosocial support, high frequency of depression, and substance abuse problems as characteristics of this group.

O'Toole and Cantor (1995) studied risk factors for suicide among Australian Vietnam era draftees and found that low intelligence as measured by the Australian Army General Classification test was related to risk of suicide, as well as to the risk of death from other external causes. More recent studies have concluded that poorer cognitive functioning is related to both passive and active suicidal ideation (e.g. Ayalon et al, 2007).

Never having been unmarried was also shown to be a risk factor for suicide, as was being divorced or separated, being unemployed and living alone. Other risk factors included social problems, genitive life events in the previous last year and expression of suicidal ideation (Thoresen et al, 2006; Thoresen & Mehlum, 2006; Thoresen & Mehlum, 2004). Indeed Thoresen & Mehlum (2006) found that while mental health problems, especially depression and psychotic disorders, were the most significant risk factors for suicide, living alone and the break-up of a close relationship still contributed to suicide risk even when controlling for mental health problems.

Psychiatric disorder

Again as in the general population (and as noted above) the presence of psychological or psychiatric disorders, including substance abuse has been found to increase the risk of suicide among veterans (Tanielien & Haycox, 2008; Zivin et al, 2007; Ayalon et al, 2007; Thoresen & Mehlum 2006; Thoresen & Mehlum, 2004; Lambert & Fowler, 1997).

According to Tanielien & Haycox (2008) depression, post traumatic stress disorder (PTSD) and traumatic brain injury all increase the risk of suicide among veterans.

Zivin et al (2007) looked at risk factors for suicide among 807,694 veterans in the U.S. and found that overall the suicide rates among a population of veterans undergoing treatment for depression were seven to eight times higher than among the general population. They also reported that veterans with substance abuse had higher suicide rates than those without. However they found that veterans with a service-connect disability had lower rates of suicide than those without. They suggested that these results may be explained by veterans with service-connected disabilities having greater access to Veteran Affairs (VA) health services and regular compensation payments to bolster their income. They concluded that as a group, veterans may be particularly susceptible to suicide because of a high prevalence of depressive disorder and co-morbid psychiatric conditions.

Unlike Tanielien & Haycox (2008) Zivin et al (2007) found the presence of PTSD to be associated with lower rates of suicide, which may be due to those people with PTSD having received more care through PTSD programs (Hampton, 2007).

While PTSD diagnosis may reduce suicide risk certain PTSD symptom clusters are predictive of suicidal ideation among veterans, in particular re-experiencing symptoms (Bell & Nye, 2007).

Finally, Reich (1998) indicated that there was a relationship between borderline personality traits, major depression and suicide attempts among a veteran outpatient population. With regard to treatment factors Gibbons et al (2007) analysed data on 226, 866 veterans who received a diagnosis of depression in 2003 and 2004. They found that suicide attempt rates were lower among patients who were treated with antidepressants than among those who were not, and among those treated with SSRIs this effect was seen in all adult age groups, suggesting that SSRI antidepressant treatment can have a protective effect. Suicide attempt rates were higher prior to treatment and decreased with the commencement of treatment.

Access to means of suicide

Ready access to means of suicide has been consistently shown to increase suicide risk in the general population and veterans may be more at risk of suicide because of their familiarity with firearms (Lambert & Fowler, 1997), which play an important role in suicide rates

especially in the U.S. where they are the most common method of suicide. Indeed Kaplan et al (2007) found that veterans who died by suicide were more likely to have done so using a firearm than their non-veteran counterparts.

Desai et al (2008a) in a study of the correlates of the use of firearms to commit suicide examined a sample of veterans who had been discharged from a psychiatric inpatient unit (n=119,159) over the four year period from 1994 to 1998. In this sample, the suicide rate was 0.89% which was high compared to the general population but comparable with other studies of suicide among psychiatric patients. Patients who were male, Caucasian, had a diagnosis of PTSD or substance abuse and lived in states with less restrictive gun ownership laws were more likely to use a firearm than another means to commit suicide. The authors concluded that gun ownership was significantly associated with the likelihood of this group committing suicide with a firearm.

Exposure to combat

Higher levels of suicidal ideation have been associated with the experience of war zone violence and with functioning as an agent of death. In addition, greater exposure to atrocities is associated with higher levels of re-experiencing PTSD symptoms, which have been associated with suicidal ideation (Bell & Nye, 2007).

Finally, Thoresen et al (2006) studied risk factors for completed suicide in veterans of peacekeeping in Norway. They found that involuntary repatriation and conflict with the military system could increase risk of suicide. People who experienced involuntary repatriation would have done so because of their inability to comply with conduct codes or to cope with the demands the military service placed upon them, but repatriation itself can be perceived as a major traumatic event with problems of social stigma. A related risk factor is an 'absent without leave' (AWOL) charge during service (e.g. Ayalon et al, 2007).

In summary, there is some evidence to suggest that the following factors contribute to greater risk of suicide in veterans:

- Being male
- Older or younger (not middle age) veterans
- White
- High school graduates
- Poor psychosocial support or social network, including being unmarried, separated, divorced, homeless
- Negative life events before military service
- Presence of psychiatric disorder, including depression and substance abuse
- Living in a rural area
- Unemployment
- Psychological treatment during service
- Involuntary repatriation, conflict with military service system
- Poor cognitive functioning or low intelligence

Protective factors that were identified are:

- Service connections
- Regular compensation payments, good income
- Anti-depressant use
- Psychosocial support

3.5 Discussion

As noted throughout this review, there is some evidence to suggest that suicide rates among veterans are elevated compared with the rest of the population both here in Australia and overseas, however this is by no means conclusive.

There are a number of methodological considerations that should be noted in considering the findings reported here.

Firstly, absolute numbers of veteran suicides are small in Australia, which limits the conclusions that can be drawn from epidemiological studies.

As noted above, ICD-10 classifies suicide under death due to external causes, including accidents and suicides. The extent of suicide can be difficult to determine reliably, and some under-reporting of suicide statistics is to be expected because of misclassification of a suicide as an accident, road-accident or disease-related death or due to reporting delays. Misclassification may be more common in deaths of older people. There may also be misreporting because of stigma, socio-cultural norms, insurance reasons, or location (De Leo, 2007).

This difficulty in ascertainment of accurate statistics is particularly important to bear in mind when making comparisons between suicide rates in veterans and suicide rates in other comparison groups. Comparison groups need to be considered carefully because of the 'healthy worker effect', so that comparison with the general population may not be as informative as a comparison with a group of veterans who were recruited into the armed forces but did not serve in active duty.

The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population provided a considered discussion of the reasons for conflicting or inconsistent reports on veteran suicide rates compared with the general population or other groups and suggests that discrepancies may largely be explained by misclassification errors and biases in reporting.⁵

Misclassification as veterans

In the US, studies that rely on death certificates and other death records may overestimate the number of veterans because anyone who has ever served in the US Armed Forces can be counted as a veteran. People who have not completed basic or advanced training due to misconduct, personality disorders, legal problems, adjustment reactions, alcohol and drug-related problems and other administrative reasons for discharge may still be classified as veterans. Similarly people who trained in the Reserve component but did not serve on active duty can be misclassified as a veteran.

Other misclassification biases

Some suicides can be misclassified as 'other external causes' of death (eg accidents, homicides) in the general population. For example in the study by Kaplan et al (2007), undetermined deaths were higher in non-veterans than in veterans. Therefore veteran suicides may be more likely to be correctly classified as suicides than those occurring in non-veterans because of the high use of firearms for suicides in veterans. Since overdoses account for a

⁵ http://www.mentalhealth.va.gov/MENTALHEALTH/suicide_prevention/Blue_Ribbon_Report-FINAL_June-30-08.pdf downloaded 1.12.08

high proportion of undetermined causes, it may be that non-veteran suicides are more likely to be misclassified as undetermined, while suicide in veterans is more likely to be correctly classified.

Similarly veteran suicides may be more correctly classified than non-veterans because of the availability of more accurate information for their death certificates, although this is speculation and no methodological studies of the accuracy of veteran death certificates have been published to date.

Unadjusted demographic differences

In the US there are large differences in suicide rates by race/ethnicity, but studies generally only adjust for gender and age. A higher proportion of veterans are white/non-Hispanic individuals than in the general population, therefore this might increase the apparent difference between veterans and non-veterans since suicide rates are higher in whites. Therefore while there is some evidence to suggest that suicide rates among veterans are elevated when compared with the rest of the population, the evidence is by no means conclusive and there is some doubt as to the reliability of these data.

Research also provides some evidence regarding risk factors for suicide in this population however these do not seem to be significantly different from the risk factors for suicide in the general population and in order to be able to determine with certainty the differences between suicide rates and risk factors among the veteran and general population better controlled studies are required.

It was beyond the scope of this review to consider levels of evidence for studies conducted using veteran samples. However bearing in mind the classification regarding levels of evidence provided above (DeLeo & Krysinika, 2007), if we are to obtain evidence of sufficient quality that it can be used to develop preventative strategies, studies that can provide Level A evidence and hence overcome some of the caveats highlighted above are certainly required.

3.6 Conclusions and recommendations

This review has provided a narrative summary of the literature on suicide rates among veterans and comparison groups. Whilst there is some evidence to suggest that rates of suicide may be elevated among this population further, good quality data on suicide rates in Australian veterans are needed. Further research on the extent of mis-classification of suicide rates is also required in order that we can examine suicide rates among this population with greater certainty.

In considering the risk factors that may be associated with suicide in Australian veterans, these do not appear to be significantly different from those among the general population. However, again more research is required in order that we can examine whether or not there are risk factors specific to Australian veterans, such as exposure to combat, upon which future preventative measures can be based.

Recommendation 8.1: It is likely that a study of suicide in a full cohort of post-Vietnam veterans will be conducted at some time in the future. Before making a decision to proceed, there should be a review of findings of:

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

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

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

Appendix 3.1 International studies of suicide in veterans

Study	Location	Sample	Year	Suicide rates	Comments
Zivin, Kim, McCarthy, Austin, Hoggatt, Walters & Valenstein (2007)	U.S.	VA National registry for Depression linked to Data Merge Initiative and National Death Index N=807,694	April 1999 – Sept 2004	88.25 per 100,000 person years 1,683 committed suicide during the study period. (0.21%)	Overall rates of suicide among depressed VA treatment population were 7-8 times higher than among the general population
Thoresen, Mehlum & Moller, 2003	Norway	Norwegian men who served one or more 6 month terms with a UN or NATO peacekeeping or peace-enforcement operation N=22,845 males, linked with general population and cause of death registries	1978 – 1995	Standardised mortality ratio for suicides was 1.41 (95% CI 1.1-1.8)	SMR reduced to 1.1 and was no longer statistically significant when adjusting for marital status
Thoresen & Mehlum, 2004	Norway	Norwegian male veterans of peacekeeping operations who served 1978 – 1995 N=22,275		73 suicides and 68 accidental deaths	There are common risk factors for alcohol-related fatal accidents and suicide – increased level of unemployment, problems in social network, negative life events in their last year, suicidal communication, major depression, alcohol or substance abuse, and psychiatric treatment (also borderline significance, increased rate of living alone).
Thoresen, Mehlum, Roysamb, & Tonnessen, 2006	Norway	45 Interviews with next of kin for deceased suicide subjects from cohort (n=22,275) of Norwegian male veterans; questionnaire data from random n=888 male veterans	1978-1995		Peacekeeper veterans who committed suicide had significantly more parental psychosocial problems in their childhood, and had experienced 3 out of 11 negative life events. Involuntary repatriation was a major risk factor for completed suicide.
Kaplan, Huguet, McFarland, & Newsom, 2007	U.S.	1986-94 National Health Interview Survey linked to National Death Index N=104,026	1986-1994	Veterans represented 15.7% of the NHIS sample but accounted for 31.1% of the suicide decedents.	Over time, veterans were twice as likely (adjusted HR 2.13, 95% CI 1.14 – 3.99) to die of suicide compared with male non-veterans in the general population.
Kang & Bullman, 2008	U.S.	Veterans of Operation Iraqi Freedom and Enduring Freedom (OIF/OEF) N=490,346	Separated alive from active duty Oct 2001 –	SMR = 1.15, 95% CI 1.03-1.69 overall For former active duty veterans, SMR = 1.33 (1.03-	Although as a group the risk of suicide was not statistically significantly different from that in the US general population, there may be vulnerable subgroups, notably active component service

Study	Location	Sample	Year	Suicide rates	Comments
			Dec 2005	1.69) For Veterans diagnosed with a selected mental disorder SMR = 1.77 (1.01 – 2.87)	members and those with mental disorders.
Bullman & Kang, 2000	U.S.	1545 Navy recruits exposed to mustard gas chamber tests compared with 2663 Navy veterans who served at the same location and time but were not exposed to mustard gas	Exposure occurred 1944-45, followed up at Dec 1995 with death certificate analyses	Crude suicide rate for overall group was 32 suicides out of 4208 veterans. Crude suicide rate per 10,000 person years for exposed group was 1.44 and not exposed group was 1.86	
Institute of Medicine, deployment related stress and health outcomes, vol 6, Washington, national academy press, 2007					There is sufficient evidence of an association between deployment to a war zone and suicide in the early years after deployment.
Boscarino, 2006	U.S.	7,924 Vietnam theatre veterans and 7,364 Vietnam era veterans	Jan 1985 to mortality follow-up Dec 2000	PTSD positive era veterans had a crude HR for suicide of 2.9 and PTSD positive theatre veterans had a crude HR of 2.6 for external cause mortality (including suicide) – after adjustment, results were still significant for theatre veterans but only marginally significant for era veterans.	
Desai, Dausey & Rosenheck, 2008a	U.S.	N=119,159 All patients discharged with a diagnosis of major affective disorder, bipolar affective disorder, PTSD or schizophrenia from psychiatric inpatient units in	1994-1998	1,057 patients died by suicide (0.89%)	High rate compared to general population but comparable to other studies of suicide in samples of psychiatric patients.

Study	Location	Sample	Year	Suicide rates	Comments
		VA			
Desai, Rosenheck & Desai, 2008b	U.S.	Three cohorts of VA mental health outpatients, 1995, n=76,105; 1997, N=81,512; 2001, N=102,184 And National Death Index data	1995, 1997 and 2001	1995 – 13.18 per 10,000 person-years 1997 – 11.41 per 10,000 person-years 2001 – 10.32 per 10,000 person-years	Finding mirrors declining suicide rates in the general population during this time period, and may reflect more effective treatment of depression with newer psychotropic medications in the VA
Macfarlane, Thomas & Cherry, 2000	U.K.	N=53,462 Gulf War veterans and a comparison group who were not deployed (era cohort)	Follow up April 1991 – March 1999	MRR for all external causes was 1.18 (0.98-1.42) With 254 deaths due to external causes in the Gulf cohort and 216 in Era cohort. Number of suicides was the same in the two groups – 51 in Gulf cohort and 50 in Era cohort.	Although Gulf war veterans report higher levels of current morbidity than those who were not deployed, there is only a very small (non significant) increase in mortality.

Appendix 3.2 Selected studies of suicide in Australian veterans

Study	Sample	Year	Suicide rates	Comments
O'Toole & Cantor, 1995	19,430 served in Vietnam theatre and 27,081 served at home in Australia, called 'Vietnam era veterans' Random sample of 727 veterans and 1059 era veterans	From day after second anniversary of enlistment to Jan 1992.	91 of 1650 died by suicide	Those who scored low on intelligence test scores, post school education, AWOL charge during service, and history of diagnosis and treatment of psychological problems had a higher rate of suicide
The Mortality of Vietnam Veterans Study (Crane et al, 1997a)	All male service personnel – navy, army, air force, N=59,520	End of Vietnam War until 31 Dec 1994	Standardised mortality ratio for suicide was significantly higher than the general population, with an SMR of 1.21 (CI 1.02, 1.42)	Risk of suicide was higher when compared with non-veterans.
Mortality of National Service Vietnam Veterans study (Crane et al, 1997b)	A supplementary study to the above study, extending the period of data collection by seven years. Undertaken to compare mortality rates among national service veterans who saw combat in Vietnam with those who did not.		The mortality rate from all causes was slightly higher in veterans who served in Vietnam (relative risk = 1.28; CI 0.97, 1.70) however suicide rates were not significantly elevated (relative risk = 1.13; CI 0.77, 1.67).	The mortality rate from all causes was slightly higher in veterans who served in Vietnam.
Australian Veterans of Korean War (Harrex et al, 2003)		2003	For Army Korean War Veterans, SMR for suicide of 1.31 (1.14-1.49)	Those who served in Korea after Dec 1951 had elevated suicide rate while those who served earlier, suicide rate was lower than expected compared to the male Australian population.
Third Vietnam Veterans Mortality Study,	All deaths among male Australian Vietnam veteran cohort from the	Retrospective cohort study of male Australian personnel	Overall SMR for suicide was 1.03 (0.93-1.13). Over time there was an	Vietnam veterans were a selected group of health, fit men at the time of the commencement of their service. SMRs increased over time as

Study	Sample	Year	Suicide rates	Comments
2005	time of completing Vietnam service to 31 Dec 2001, compared with number of expected deaths based on mortality of the Australian community	who served in Vietnam from May 1962 to July 1973	increase in mortality from suicide. SMRs for 1963-79 was 0.86 (0.7-1.02); for 1980-1990 was 1.06 (0.89-1.23) and 1991-2001, 1.15 (0.97-1.33)	the health worker effect diminished. Australian studies have shown an increase in overall mortality for Vietnam veterans, which is highest among Navy personnel. There was a statistically significant increase in suicide risk associated with Vietnam service.
Morbidity of Vietnam Veterans; a study of Australia's Vietnam Veteran Community, DVA, 1998 And Validation Study AIHW, 1999	Self reported survey of 49,944 male veterans about their own and their children's health		Average suicide rate over the years 1988 – 1997 was 46.6 suicides per 100,000 among Veterans' children, compared to 14.8 suicides per 100,000 for Total Australia	Suicide among children of Vietnam veterans was three times more common than expected
Australian Gulf War Veterans Health Study (Sim et al, 2003)	1,456 Gulf War veterans were compared with 1,588 members of the Australian Defence Force who were eligible to be deployed but were not deployed	2003	Suicide rates were not specifically reported. Mortality rates from all external causes were similar to the comparison group (relative risk = 1.1). Of the deaths due to external causes, one-third were due to intentional self harm, which was the same for the comparison group.	Caution is advised when interpreting these data due to small numbers.

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Section 4 Rapid literature review of suicide prevention programs

There are limited opportunities for researchers to assess the impact of suicide reduction programs on rates of suicidal behaviour, due to factors such as: the relative rarity of completed suicide; incomplete reporting of suicide attempts; the likelihood of confounding variables; and the indirect relationship between broad-based strategies and suicide rates at the population level.(Mackenzie, Blamey et al. 2007; Rodgers, Sudak et al. 2007; Lifeline Australia ND)

The majority of studies therefore evaluate suicide prevention approaches in terms of their ability to strengthen organisational and practitioner skills in risk detection and follow-up action, without assessing program impact on suicidal behaviours. Samples of these studies are presented here.

However, a small number of studies report with some confidence on suicidal outcomes. These form the core of this review.

4.1 Military studies

Impacts on suicidal outcomes

The most compelling military study to date comes from the US, where Knox et al (Knox, Litts et al. 2003) conducted a quasi-experimental cohort study to assess the impact of a suicide prevention program within the US Air Force.(Knox, Litts et al. 2003) The program was initiated in 1996 in response to a severe increase in suicide rates within the Air Force over the years 1990-1994.

The intervention followed a risk reduction and early detection approach, using community- and institution-wide education and training to raise awareness of suicide risk factors, strengthen social support, encourage help-seeking behaviours and reduce any associated stigma. The study population comprised 5,260,292 US Air Force personnel on active duty between the years 1990-2002, with personnel serving between 1997-2002 forming the treatment group.

The study showed a significant drop of 33% in the relative risk of suicide for personnel serving after the introduction of the program, and significant reductions in other behaviours that were likely to be addressed by the intervention. Hence, relative risk for homicide decreased by 51%, accidental death by 18%, severe family violence by 54%, and moderate family violence by 30%. Risk of mild family violence increased significantly by 18%, attributable perhaps to better early detection systems. The authors concluded that the Air Force's thorough and willing institutionalisation of the program led to a fundamental shift of social norms around mental health issues. This systemic change made the intervention's considerable impact possible.

A similar intervention adopted by the conscription-based Norwegian Armed Forces was found to be equally successful in reducing suicide rates.(Mehlum and Schwebbs 2001)

Another European study reports decreased incidences of suicide in the Army of Serbia and Montenegro in the two years following the implementation in 2003 of a suicide prevention program.(Gordana and Milivoje 2007) The perspective of the authors and the military is that suicide is a “problem of maladjustment to the military environment.” The intervention had three key strategies: (1) improved soldier selection processes; (2) education on suicide risk detection; (3) “social concern and mental health work with all employees”. While the intervention appears to have been successful, it is difficult for the reader to determine its success due to: a selective reporting of yearly suicide rates; a lack of clarity about differential rates of suicidal behaviours between soldiers and professional staff; and the unaccounted influence of external factors on suicide rates, namely the social and political upheavals in Serbia and Montenegro over the preceding decade.

Other evidence from the US concerns ‘unit watch’, a strategy used widely in the US Army to minimise the risk of suicide or homicide in individuals, when that risk is not great enough to warrant hospitalisation. The watch may involve the constant companionship of a ‘buddy’ during daylight hours or extend to a more formal 24-hour watch regime. The watch procedures involve limiting a soldier’s access to lethal means, drugs and alcohol; reducing exposure to situations and individuals that induce stress or suicidal / homicidal ideation; and ensuring the maintenance and follow-up of clinical treatment.(Payne, Hill et al. 2008) Payne et al (2008) state that the unit watch system is on the whole less stigmatising than hospitalisation, and offers a better recovery environment through the maintenance of normal operational duties as far as possible. While the unit watch system has not been formally evaluated, data for the years 2004 and 2005 suggest that the procedures when implemented reduce the incidence of completed and attempted suicide to close to zero.(Payne, Hill et al. 2008)

Training effectiveness

In the study by Matthieu et al (2008), the impact of suicide prevention training was assessed in a sample of 602 clinical and non-clinical staff of Vet Centers across the United States.(Matthieu, Cross et al. 2008) The training comprised a one-hour multimedia presentation followed by peer group practice of three gatekeeper skills - “question, persuade and refer.” Pre- and post- measures of perceived knowledge, self-efficacy and declarative knowledge showed significant improvements in scores for both clinical (n=428) and non-clinical (n=174) staff, with the effects being higher in the non-clinical (i.e. administrative and community outreach) cohort, who may have not received this type of training before.

4.2 Civilian studies

Impacts on suicidal outcomes

The *Signs of Suicide* (SOS) program, which operates in many hundreds of schools in the US, is one of the few interventions to be evaluated with a randomised controlled trial (RCT). This type of study design provides the highest level of evidence for program effects due to the random assignment of large numbers of participants to treatment and control groups, thereby minimising the probability of important pre-trial differences between the two groups.

SOS teaches “high school students to respond to signs of suicide in themselves and others as an emergency, much as one would react to signs of a heart attack.”(Aseltine, James et al. 2007) Presentation of the program consists of an educational video and a screening instrument for depression and suicidality.

Aseltine et al (2007) randomly assigned a total of 4133 high school students at nine high schools to treatment and control groups.(Aseltine, James et al. 2007) Three months after program delivery, the students were surveyed anonymously on their knowledge, attitudes and behaviours towards depression and suicide, including suicidal ideation and attempts within the past three months. The intervention group were 40% less likely than controls to report suicide attempts (intervention group attempted suicide rate for three months = 3.0%; control group = 4.6%). More modest gains were found for attitude and knowledge, and there were no statistical differences for suicidal ideation and help-seeking behaviours. This study provided greater statistical power than previous randomised trials of the same program, enabling confirmation that the SOS program works effectively for adolescents of different ages, race, ethnicity and gender.

Another US study evaluated the impacts and benefit-cost ratio of a suicide prevention program targeting members aged 15-19 years of a Native American tribe in New Mexico.(Zaloshnja, Miller et al. 2003) As part of the program: a new social worker position was added to the existing small mental health team; a school-based project trained 10 to 25 youths per year to act as peer helpers; and broad-based community education, outreach and screening processes were implemented. Pre-intervention data on suicidal acts in the years 1988-1989 were compared with post-intervention data from 1990 to 1997. The rate of suicidal acts in persons aged 15-19 years declined from 59.8 per 1000 in 1988-1989 to 8.9 per 1000 in 1990-1991, 9.2 in 1992-1993, 17.6 in 1994-1995, and 10.9 in 1996-1997. The quality of life savings from the reduction of fatal and non-fatal suicidal acts were estimated to be US\$1.7 million annually, with a benefit-cost ratio of 43 and a cost per QALY saved of US\$419. The authors stress that the pre-intervention data may have contained anomalously high rates of suicidal acts – appropriate data was not available to establish longer trends – and that the success of the program would have been contingent on the existence of a comprehensive community mental health care and education system composed of the program and existing resources.

A retrospective study by Gibbons et al (2005) examined the association between rates of suicide and prescription for antidepressants, using county level data for the whole of the US in the years 1996 to 1998.(Gibbons, Hur et al. 2005) The authors found no overall statistical significance between all prescribed antidepressants and suicide rates. However, the prescription of selective serotonin reuptake inhibitors (SSRIs) and/or new-generation non-SSRI antidepressants had a significant negative association with suicide rate (maximum marginal likelihood estimate [MMLE] = -0.15, $P < .001$); and the prescription of tri-cyclic antidepressants (TCAs) had a significant positive association with suicide rate (MMLE = 0.20, $P < .001$). Modelling suggested that phasing out the use of TCAs could reduce the national suicide rate by 33%. The authors noted that TCAs were prescribed more often in rural and poorer counties; and that the use of TCAs may contribute directly to completed suicides due to the greater likelihood of non-compliance stemming from their adverse effects, and the greater toxicity of TCAs in overdose.

Training effectiveness

Applied Suicide Intervention Skills Training (ASIST) is a two-day training program developed at the University of Calgary and marketed internationally by LivingWorks Education. ASIST is targeted at professional and lay caregivers, training them to recognise suicide risk and apply appropriate risk reduction methods. Numerous evaluations of the program's effectiveness in terms of learning outcomes have been undertaken (LivingWorks Education 2007): just one is included here for illustrative purposes.

The study of ASIST in Scotland by Griesbach et al (2008) used data from: the national ASIST database; a survey of 534 former course participants from the years 2003-2007; and interviews or focus groups with a sub-sample of 22 former participants, 28 ASIST trainers, and 19 key stakeholders. (Griesbach, Dolev et al. 2008)

Course participants reported considerable increases in their knowledge, skills and confidence as a result of their ASIST training, as would be expected from an internationally recognised program. Follow-up data suggested that participants were more likely to intervene with persons at risk of suicide after their training than prior to training. Some respondents credited the ASIST program with reducing the stigma associated with suicide, and raising awareness in communities. The evaluation did not assess the impact of ASIST on rates for attempted or completed suicides, citing barriers including: the unreliable reporting of suicidal acts; the likely time lag between intervention and effect; and the critical mass of program trainees required to achieve measurable effects.

Systematic reviews

Mann et al (2005) conducted a systematic review of the global evidence published between 1996 and June 2005 for the effectiveness of suicide prevention strategies. (Mann, Apter et al. 2005) Suicide experts from 15 countries assessed a shortlist of 93 out of 5020 publications, comprising: 10 systematic reviews and meta-analyses; 18 randomised controlled trials; 24 cohort studies; and 41 ecological or population based studies.

The authors identified five major approaches in suicide prevention:

1. Awareness and education campaigns targeted at the general public, primary care physicians, or community and organisational gatekeepers.
2. Screening to identify at-risk individuals.
3. Treatment interventions, comprising pharmacotherapy, psychotherapy, and/or case management following attempted suicide.
4. Restriction of access to lethal means.
5. Media guidelines on reporting suicide.

The authors presented a narrative synthesis of evidence for each approach, and estimated their relative impacts on suicide rates. In order of estimated impact, the most effective approaches were:

- physician education (22-73% reduction)

- gatekeeper education (33-40% reduction)
- the restriction of lethal means, specifically domestic gas, barbiturates and guns (1.5-23% reduction)

The assessment of gatekeeper education was based on the studies conducted in the Norwegian Army (Mehlum and Schwebs 2001) and US Air Force (Knox, Litts et al. 2003) mentioned earlier. Evidence suggested that the remainder of the approaches have the capacity to reduce suicide rates, pharmacotherapy in particular (3.2% reduction), but further studies were required.

The recommendations of the Mann et al review underpin the evidence base for the Australian Government's *Living is for Everyone* policy framework. (Department of Health and Ageing 2008) The review's conclusions were also echoed by Beautrais et al (2007), who however advised against the adoption of school-based suicide awareness programs, in the belief that there was little evidence for their effectiveness and legitimate concerns regarding their safety. (Beautrais, Fergusson et al. 2007)

Rodgers et al (2007) reviewed 55 evaluations of suicide prevention programs with the purpose of developing a best-practice registry. The authors identified 24 evaluations that met minimum methodological standards and short-listed twelve programs to be placed on the registry: four of the programs were deemed to be effective, with the remaining eight programs described as 'promising'. (Rodgers, Sudak et al. 2007)

There is little evidence that the establishment of a suicide prevention centre is a sufficient strategy in itself. Lester (1997) found just 7 out of 14 studies that compared suicide prevention centres with suicide rates in surrounding areas to provide slender correlational evidence of preventive effects. The author concluded that finer measures such as the numbers of staff and clients should be used to measure strategy effectiveness, rather than the mere existence of centres. (Lester 1997)

4.3 Summary comments

While the evidence-base for the relative effectiveness of suicide prevention approaches is not extensive, there are sufficient recurrent themes to envisage the key features of a successful intervention. Tentatively, these would be:

- Embedding of the suicide prevention program within a broad-based community education, treatment and support service that minimises stigmatisation.
- Delivery of the following core program components:
 - 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
 - appropriate medication regimes.
- Existence of a strong institutional context for program delivery that enables systemic change, as suggested by the success of the US Air Force and school-based SOS programs.

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Part B - Services for Australian Veterans with mental health problems

Section 5 Transition from the ADF

5.1 Introduction

It is very important that transition occurs seamlessly as otherwise a rupture can occur and members may only present many years later when their mental health problems and their consequences are more severe and intractable.

Around 5,000-7,000 members discharge from the ADF each year. About 10% of these do so for health reasons (500-700), with 10-15% (60-90) of these in turn being related to mental health.

The principal transition services provided to members are:

- Transition Support Services and ADF Transition Centres;
- Transition Management Service;
- Integrated People Support Strategy;
- Stepping Out Program;
- *Lifecycle* Transition Mental Health & Family Collaborative

5.2 Transition Support Services and ADF Transition Centres

There are 19 Regional ADF Transition Centres around Australia. These Transition Centres are part of National Operations Division with the Technical Authority sitting in Personnel Support Services, which is run in turn by the Defence Support Group (DSG). This nationally-based program was introduced in 2001 and was superimposed on earlier arrangements on base where the Adjutant or Chief Clerk constituted a Discharge cell and had full responsibility for transition activities. They would also determine the content of transition materials provided to members.

As stated on the Transition Support Services' website, the aim of the Transition Centres is to assist members to complete their requirements with the ADF.⁶ They also aim to assist members and their families to become separation ready. They provide information relevant to the members' needs and link them to bodies such as the ADF Rehabilitation Program, DCO, Defence Families, Defence Housing, DVA, ComSuper and Centrelink.

The Regional Transition Coordinator organises an initial and final one-on-one interview with the separating member.

They conduct 2-day Transition Seminars ADF members (and their families if they are available).⁷ As stated on their website, they cover the following topics:

⁶ My nearest ADF Transition Centre
(http://www.defence.gov.au/transitions/my_nearest_adf_transition_centre.htm accessed 8 Jan 2009)

⁷ Transition Support services. Seminar content
(http://www.defence.gov.au/transitions/when_is_the_next_transition_seminar_on.htm#SeminarContent accessed Jan 6 2009)

- Your Career and You (Day 1) The tools of Good Career Decision and Management; Job Search Strategies; Networking; Job Application; Resume; Winning the Interview; Managing Referees; Resources; Making a Decision and Action Planning.
- Your Money and You (Day 2) Personal Wealth Creation and Financial Planning; Financial Advisers – the Facts and the Fiction; Starting, Operating and Selling a Business; Protecting your Assets; Private Health Insurance; ComSuper presentations on MSBS and DFRDB; Transition Support Benefits; Transition Support and Administration; Department of Veterans' Affairs and VVCS; Reserve Service.

Educational institutions and ESOs mount information stands at the Seminars for member interest

As further stated on the Transition Support Services website, the Career Transition Assistance Scheme (CTAS) provides a wide range of career transition support to separating ADF members.⁸ As well as being involved in the Transition Seminars, CTAS provides on-line information. It also provides career transition training, career transition management coaching, curriculum vitae coaching and financial counseling. This is available for members with 12 or more years of service as well as members transitioning-out for medical reasons, irrespective of their number of years of service. Training that is supported is set at an equivalent (rather than upgraded) level to the member's previous educational level.

The Transition Centres provide information and access to ComSuper and service pensions so that members are aware of their full entitlement and are able to make effective applications. Members may be entitled to compensation for the effects of an injury, disease or illness which they believe is related to their service in the ADF. In this event, they are encouraged to lodge a claim for compensation with the Department of Veterans' Affairs (DVA), even if their medical condition is not currently causing any problems. If liability is accepted by the DVA, eligibility for various forms of compensation, rehabilitation and, in some cases, repatriation benefits can be assessed.

Welfare and Pensions Officers who are volunteers working within Ex-service organisations (ESOs) can provide further assistance with claims for compensation to veterans and former serving members. The Training and Information Program (TIP) provides training and information for these Officers.

Some stakeholders stated that the amount of information provided to members at these seminars is excessive and it is difficult for members to absorb all of it.

5.3 Transition Management Service

The Transition Management Service (TMS) was introduced in 2002 (after earlier trials in 2000-1) particularly to ensure and expedite the lodgement of DVA

⁸ Career Transition Assistance Scheme (<http://www.defence.gov.au/transitions/support/ctas/ctas.htm> accessed at Jan 9 2009)

compensation claims. There are nine TMS coordinators and offices around Australia currently.

As stated in the fact sheet on the DVA website, the purpose of the TMS more generally is to assist full-time serving members of the ADF who are being transitioned-out on medical grounds.⁹ DVA provides the TMS on behalf of the ADF, particularly in regard to rehabilitation and compensation services. However, assistance is provided to members whether or not they have lodged a compensation claim.

The aim of the TMS is that eligible members should make a successful transition to civilian life by ensuring that they have access to the full range of available information and services. TMS is a voluntary service and free of charge to members – although in fact 95-97% of them make contact with the TMS, initially at least with more variable subsequent level of use. The ADF Transition Centres and the ADFRP also advise TMS of members who are separating medically.

The intention is that there is a ‘seamless’ transition from military service to civilian life. This can only happen if the ADF and DVA cooperate fully to ensure this. Thus TMS Coordinators work in collaboration with ADF Transition Coordinators, CTAS staff and ADF Rehabilitation Program Case Managers.

ADF members can use the TMS if they are presently or soon likely to become MEC4. In other words, they are likely to be, or actually will be transitioning-out on medical grounds eg if they are referred to a MECRB or if it confirms they are to be transitioned-out. The TMS coordinators also develop for the member a 'Personal Transition Action Plan' on maximising entitlements, possible future employment options, post-discharge medical matters, superannuation, housing, financial planning, insurance, compensation, and other general assistance.

TMS staff may assist members who are relocating to new towns and cities, perhaps in country areas on separation on accessing the best treatment and rehabilitation services in their new locations.

An important benefit for separating member for mental health reasons is their eligibility for a White Card that pays for treatment of PTSD, anxiety and depression.

5.4 The Integrated People Support Strategy

The Integrated People Support Strategy (IPSS) was established in 2007 by then Minister Bilson. It was established as a 12-month pilot program at the Edinburgh RAAF base in South Australia and Fleet Base West, HMAS Leeuwin and RAAF Pearce base in Western Australia. It has now rolled-out through Townsville and now exists nationally. An evaluation report on the pilot stage has been accepted and has resulted in the IPSS being implemented nationally.

⁹ Transition Management Service (<http://www.dva.gov.au/factsheets/default.htm> accessed 7 Jan 2009)

It is also delivered by Personnel Support Services, in turn part of the Defence Support Group (DSG) (albeit a different section of PSS). It is endorsed by the CDF and aims to reinforce ADF Transition Support Services.

It has four main aims:

- Through Life Support - members are fully informed about all available health, illness and related support services such as financial advice;
- Separation Ready - members receive all relevant services so that they are fully prepared to return to civilian life;
- Separation Reconciliation - members have resolved all outstanding defence-related matters before separation;
- Separation Review – conduct of a review at three to six months post-discharge to monitor progress towards achievement of the three other goals.

The IPSS team, which is based in Campbell Park, Canberra has developed transition-related materials for member use for delivery by all Transition Centres. This will ensure that members, wherever they are based in Australia will receive the same set of materials.

The IPSS also organise Regional Stakeholder Forums that aim to assemble all relevant service providers (DVA, ComSuper, DCO, Defence Families, the Regional ADF Rehabilitation Coordinator, Senior Medical Officer, Chaplain and Defence Housing and ADF Financial Services.

IPSS make no special arrangements for members transitioning-out for medical reasons. It believes that ADF Rehabilitation Program's Program Case Managers are well placed to undertake this role. This does not currently happen and they would need to extend their role to do this. VVCS report that very few members who indicate on their IPSS questionnaire that they wish to talk to DVA or VVCS wish to take up the offer when approached by VVCS.

Since the TMS was established in 2003 both the IPSS and the ADF Rehabilitation Program have been rolled-out. In addition members may need not only to make contact with others organisations for income support other than DVA such as Military Superannuation and Centrelink.

As a result, there is now a lively debate in the ADF whether TMS and IPSS provide the same service and whether TMS can interact with the ADF Rehabilitation Program as well as the ADF-based IPSS – see Section 5.4 below. DVA is of the view that the two programs are complementary. IPSS can initiate earlier contact with members and TMS can interact more frequently with members transitioning-out on medical grounds because of its particular focus on them.

Some stakeholders commented that IPSS and transition services generally require greater promotion and support by commanding officers to be most effective. This may be an unanticipated negative consequence of responsibility for transition services being transferred from bases to DSG.

One consideration is that a service aimed entirely at members transitioning-out for medical reasons, such as TMS will not capture all members with medical problems.

This is because a number of these will only declare themselves at a future distant time eg late-onset PTSD.

5.5 Stepping Out Program

As stated on the Stepping Out website, the Veterans and Veterans Families Counselling Service (VVCS) offer the Stepping Out Program to assist members in their transition to civilian life.¹⁰ It is a 2-day program available nationally through the 15 VVCS centres. It is voluntary and free of charge to all ADF members and their partners, who are separating or recently separated from the ADF. It is delivered by VVCS psychologists and social workers.

The program provides information and skills to manage the transition to civilian life. Topics include the experience of change as part of life, the transmission from ADF to civilian life, skills for planning ahead, expectations, plans and troubleshooting and maintaining relationships and seeking support.

Stepping Out originated in Townsville where there are very good relations between the ADF and the VVCS.

It has offered a number of courses but some have had to be cancelled due to insufficient numbers. Stepping Out is still not well known in the ADF and only has limited time to present at the Transition Seminars and needs to be better promoted. A concern was expressed that its marketing with a focus on psycho-social issues could be offputting for some members.

5.6 The Lifecycle Transition Mental Health & Family Collaborative

The full name of this program is the Transition Mental Health and Family Collaborative (Townsville) which comprises two of the Australian Government's Mental Health Lifecycle Initiatives for Veterans and Former Serving Members. It is being conducted by ACPMH on contract with DVA.

This program is being piloted in Townsville (Lavarack Barracks and RAAF Townsville) and Cairns (HMAS Cairns) starting November 2008.¹¹ It aims to improve the level of engagement, assistance and treatment for ADF members (as well as their families) who are transitioning-out and experience, or are at risk of experiencing mental health problems.

There are five priority areas:

- Collaboration improved inter-agency collaboration;
- Engagement effective engagement and communication practices;
- Recognition better recognise mental health problems and related issues;
- Families improved family sensitive and inclusive practices;
- Interventions more effective advice, support and treatment.

¹⁰ Stepping Out Program (http://www.dva.gov.au/health/vvcs/group_programmes_doco/P01433.pdf accessed 7 Jan 2009)

¹¹ A/Prof John Pead – pers comm

The Lifecycle initiative does not aim to be a new pilot working alongside other programs.

Rather it aims to support both the IPSS and TMS by working with agencies that are providing the most important transition services to members with, or at risk of mental health problems. ACPMH will meet with individual agencies monthly and convene three joint meetings of agencies.

5.7 Defence Links - The Interdepartmental Working Group (IWG)

This whole of Government Initiative involves the ADF and DVA.¹² More recently, these two Departments have been joined by:

- ComSuper (which operates the Military Superannuation and Benefits Scheme (Military Super) and the Defence Force Retirement and Death Benefits Scheme (DFRDB);
- Centrelink;
- Department of Families, Housing, Community Services and Indigenous Affairs (FaCHSIA); and
- Department of Human Services

A new Separation Health Examination is being trialled in the Wagga and Canberra regions between Nov 2008 and Feb 2009. It will include medical information needed by DVA and ComSuper as well as an application form for compensation or superannuation benefits. The intention is to reduce the number of medical examinations that members need to attend in submitting claims for disability to DVA and ComSuper. The number of claims in Canberra to DVA and ComSuper will be compared with other regions during the trial.

While other progress has been made (eg DVA, ComSuper, Centrelink and FaCHSIA agreeing in principle to adopt a common policy definition for what constitutes a member of a couple), some ESOs expressed impatience at the pace of decision making by the IWG.

There are other forms of government provision of income maintenance relevant to members transitioning-out eg service pensions administered by DVA as well as disability support pensions and Family Tax Benefit supplements by Centrelink. These are within the remit of the IWG.

5.8 Role of the ESOs in the transition process

ESOs have a relatively small role during the transition process. The TIP Chairman for the Region has a role at the IPSS Regional Stakeholders Forum. ESOs have a limited time to speak to members attending Day 2 of the Transition Seminars and are also able to mount information stands at these seminars. Some ESOs wish to establish a

¹² Defence Links Section Whole of Government Initiative
(http://www.dva.gov.au/adf/docs/IWG_Update.rtf accessed at Jan 7 2009)

more permanent presence on base with advocates to assist members in submitting compensation claims to DVA. The central role that the RSL had anticipated in the IPSS has not eventuated.

5.9 Programs and schemes impacting at both ends of the transition process

If the member has a chronic (mental) condition problem, they are likely to be in contact with rehabilitation services both before and after discharge. Before discharge, this will involve the ADF Rehabilitation Program with

- the Rehabilitation Coordinator having delegated powers from the Service Chiefs under the Military Rehabilitation and Commission (MRCC); and
- the Program Case Manager (nominated by the contract agency providing services) who has a more direct service role.

After discharge, the MRCC (if relevant) uses ComCare to provide rehabilitation services through an Approved Rehabilitation Provider appointed by the contract agency providing services.^{13 14} The handover desirably should be as seamless as possible. If the member is not relocating on discharge, it is good practice if the same rehabilitation practitioners provide services both pre- and post-discharge. If the member is relocating on discharge, TMS is able to assist to provide the most appropriate agencies and practitioners – see Section 5.3 above.

It should be noted that the ADF Rehabilitation Program offers clinical but not vocational rehabilitation. The latter usually only occurs after the acceptance of liability under a veterans compensation scheme or a disability provision of Military Super. This usually occurs post- rather than pre-discharge. Some financial assistance is available to members separating with medical reasons for vocational retraining purposes is available through CTAS as noted in Section 5.2 above.

As also noted, the separating member can make claims to one or more of the veterans compensation schemes administered under the Military Rehabilitation and Compensation Act (MRCA), the Veterans Entitlement Act (VEA) and the Safety Rehabilitation and Compensation Act. These will be discussed in further detail in Section 6. The other income maintenance schemes (military superannuation scheme as well as non-military pensions and benefits) are noted in Section 5.7 above. This complex array of compensation and other schemes is particularly confusing to the separating member with mental health problems. Both IPSS, TMS and ESO advocates all offer services to assist the member to make an effective application. The Separate Health Examination trial of the IWG – see Section 5.7 - if successful, will also simplify the processes and steps involved.

¹³ The nomenclature is confusing here as what ComCare describes as an Approved Rehabilitation Provider is what the ADF describes as a Program Case Manager.

¹⁴ The applicable rehabilitation scheme under the Veterans Entitlement Act (VEA) is the Veterans Vocational Rehabilitation Scheme (VVRS).

5.10 Transition culture and context

Many stakeholders commented on the difference in cultures between the ADF and DVA and the impact of this on separating members. In the ADF, a comprehensive range of services and benefits free of charge to members are available to them and to which they are directed by the chain of command. These end, however at discharge including Transition Services (though see the Separation review goal of IPSS in Section 5.4 above). For medically separating members CTAS entitlements can be extended for up to 12 months post-separation, and in some cases, particularly for those members with PTSD or extensive injuries, longer periods of time have been approved to support the member.

Post-discharge circumstances are different - DVA no longer provides direct services, with the exception of VVCS, since responsibility for Repatriation Hospitals has been transferred to state public hospital systems. DVA is rather the funder of a comprehensive range of services, benefits, aids and appliances. DVA does not therefore initiate contact with former members but waits for them to do this. It may be an unfamiliar experience for the former member to be proactive in this way as they were more used to being reactive in the ADF.

Some also commented on the fact that these differences were exaggerated by there being two rather than one Departments involved and since the election of the incoming government, two rather than one Ministers.

The member will also bring to their transition period, their personal circumstances frequently arising from difficulties in adjusting to service life post-deployment. There may be family problems or mental conditions such as Post Traumatic Stress symptoms or an adjustment disorder. If they have been downgraded to MEC4, they know their career with the ADF is at an end. The member may in any of these circumstances wish to blame the ADF. Some may feel that their sense of vocation has not been recognized or even exploited by the ADF. This makes them susceptible to contact with other separating members or some ESO advocates who may encourage them to seek a large compensation payout. Focus groups conducted at Enogarra indicated that members had very little knowledge of services offered by DVA and were mainly aware of the Gold Card and TPI.

The transition period can be quite extended. First, there is the period before the MECRB when transition seems likely but not certain. A significant proportion of TMS clients in fact do not transition-out but have their MEC status upgraded or are issued with a Medical or Skills Waiver at the MECRB. At this stage, members who are likely, but not certain to transition-out are reluctant to lodge a DVA compensation claim since it may affect their ability to deploy. This affects their interaction with the TMS.

After the MECRB confirms the MEC4 status of the member, there is a 3-4 month period, varying slightly across the three single forces before separation. This may be delayed however if the necessary transition processes have not been completed. Delays to locate and assemble medical files both across bases and from the locations

of their deployments will be important here.¹⁵ During this time, the member may be on convalescent leave but in any event are unlikely to be with their unit. At this time they may suffer low morale and feel disengaged and resentful. This may be compounded by the fact that some members are young, poorly educated and lack life skills.

One final problem is that not all former members are veterans yet some have been exposed to traumatic stress events such as the cleanup of the post-tsunami in Aceh and exchange of fire with illegal Indonesian fishing boats.

5.11 The Keeping In touch program

There is a proposal within DVA to establish a Keeping in touch program. This program would have some of the features of an alumni association of an institution such as a university or school. The aims of alumni associations generally are to keep members acquainted with events occurring at the institution both for the benefit of the individual and the institution. Individuals are informed of matters of interest and advantage to them, such as forming social networks. The institution gains a network of supporters who can be a source of funds and influence.

To establish an alumni association requires recording contact details (email, mobile telephone number, forwarding address and next of kin address) of individuals when they leave the institution. A database can then be established and the association can then communicate with members on a regular basis about events such as reunions and other occasions.

A Keeping in touch program would have some but not all features of an alumni association. It would have two important advantages for DVA and the ADF. It would communicate to the individual that their ongoing involvement with defence was important to the ADF. It could promote reunions but also health promotion and mental health promotion seminars and groups both new and well-established within the veteran community.

There may be other ways that the ADF can recognise the contribution of members who are transitioning-out for medical reasons, including mental health.

5.12 Assessment

This overall assessment is based on a review of technical documents, stakeholder input and public submissions. A summary of themes arising out of both individuals and organisation submissions relevant to *Transition from the ADF* are included in Appendix 1.

In principle, a seamless discharge is important for all ADF members, transitioning-out for medical reasons. Services should start as soon as possible after first notification of intention to discharge and could continue for a period beyond discharge (to, say 12 months) so to ensure that any compensation and superannuation matters that had not been fully processed at discharge had been so. A number of services with either the ADF or DVA responsible have now been established to support this. There does seem

¹⁵ This timelag reflects the absence of a robust electronic health information system in the ADF.

to be however duplication in the services offered by the IPSS and TMS which needs to be resolved. Both services focus on comprehensive information dissemination though IPSS has the additional aim of promoting communication and coordination between agencies. Neither, as presently organised have the skills to engage with members with established mental health problems or to detect members with as yet unrecognised problems.

The Lifecycle Transition Mental Health and Family Collaborative can make a real contribution in this regard by supporting and training IPSS/TMS staff members.

It is likely that some additional expertise may be needed to engage with members with mental health problems who are currently unengaged and not progressing well through the stages of their transition. This could be their Rehabilitation Program Case Manager or the mental health practitioner most involved in their treatment either on base or in the VVCS.

Joint responsibility of these services by ADF and DVA is highly desirable. ADF is better able to engage early including with the ADF Rehabilitation Program. DVA is better able to engage early with lodging of compensation claims. Other agencies could be involved with a relevant interest such as ComCare (representing Military Super and DFRDB) and Centrelink.

Families should be welcomed into the broad 'Defence family'. They should more specifically be invited to participate in transition activities. They bring an important perspective, interest and insights to bear that should be beneficial to the transition process. A redesigned Stepping Out program could be a suitable vehicle for this. To do this it would need to be better connected with the Transition Seminars.

The ESOs currently have a small role in the transition process. As noted some ESOs wish to establish a more permanent presence on base as advocates to assist members in submitting compensation claims to DVA. Some ESOs have put policies in place to cooperate with other ESOs and avoid such practices as competing for members. The future role for advocates has been however the basis for comment both in the Doogan Inquiry.¹⁶ Both argue for the need for further training and accreditation of advocates to ensure that they are able to provide professional advice across all three veterans compensation acts including MRCA with its focus on rehabilitation as well as compensation. It would be counterproductive therefore to move to an expanded role for advocates on base at this stage.

5.13 Conclusions and recommendations

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

¹⁶ Doogan CM (2007) Investigation/Inquiry report for the Department of Veterans Affairs and ComSuper relating to their dealings with the later Mr Geoffrey Gregg:40.

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

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

It is important that members of the ADF who transition out for reasons for 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, post-deployment reinterpretation of the ADF experience. This is most undesirable in both personal and economic terms for the individual, ADF and community.

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

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

Section 6 Veteran compensation schemes and mental health

6.1 The Veterans' Entitlement Act

Before 1986, the Repatriation Act (1920) was the legislative basis for the main military compensation scheme in Australia for operational and peacekeeping activities. Various subsidiary Acts also existed covering various post-World War 2 operational areas such as the Repatriation (Far East Strategic Reserve) Act. There was also the Seamen's War Pension and Allowances Act (1940).

The Veterans' Entitlement Act replaced these Acts in 1986 and remained the principal military compensation scheme for operational activity until June 2004 when the Military Rehabilitation and Compensation Act (MRCA) came into effect. In addition, it provided coverage for peacetime service and continued to do so till 1994 with the passage of the Military Compensation Act.

Nevertheless it still remains the Act under which the very large majority of veteran compensation claims are submitted and determined. This is because it covers all such claims which originated before July 2004 (32,287 compared with 2,450 under MRCA in 2007-8). While this preponderance will reduce over time, this will be only gradual as there are still a large number of claims being made by World War 2 and Vietnam veterans.

The veteran making a compensation claim under the VEA becomes eligible for a DVA disability pension if their claim is successful.¹⁷ Four rates for this pension exist - the General Rate, Intermediate Rate and Special (Totally and Permanently Incapacitated [TPI]) Rate as well as the Extreme Disablement Allowance (EDA).¹⁸ The Special Rate pension is usually known as the TPI. The General Rate pension can be awarded in part from 0-100%. The EDA is available to veterans over 65 years who are ineligible for the Intermediate or Special rate pension but have very severe disabilities. It is worth 150% of the General Rate pension.

There is also a Temporary Special Rate Pension. If a member suffers deterioration in their condition they may be approved to move from the General rate pension to the Temporary Special Rate Pension for a period of time. At the end of this time, they will be reviewed to determine if the deterioration has ended or is continuing. Veterans on a (part) General Rate pension may move from one to another percentage level.

TPI disability pensioners can engage in up to 8 hours of work per week, Intermediate rate pensioners can engage up to 20 hours and General Rate pensioners can work up to full time.

¹⁷ More accurately the Repatriation Commission (RC) is the statutory body approving veterans' compensation under the VEA. The DVA provides advice to the Repatriation Commission and implements its decisions.

¹⁸ Department of Veterans Affairs DVA Factsheet IS30 Pension Rates, Limits and Allowances Summary (<http://www.dva.gov.au/factsheets/documents/IS30%20Pension%20Rates,%20Limits%20and%20Allowances%20Summary.pdf> - accessed Jan 14 2009)

Veteran making an application to DVA have to establish Liability for their injury/disability. This has been established by the application of the Statement of Principles (SoPs) of the Repatriation Medical Authority (RMA) since 1994.

As stated on the RMA's website, the major function of the RMA is 'to determine Statements of Principles in respect of particular kinds of injury, disease or death, based on "sound medical-scientific evidence" for the purpose of applying the applicable standards of proof relating to veterans' matters' – for a further discussion of the SoPs, see Section 7.3.¹⁹

For operational activity as well as warlike and peacekeeping activity, service connection needs to be demonstrated at a "reasonable hypothesis" standard rather than at a "reasonable satisfaction" (or "balance of probabilities") standard, which is used for which is used for all applications under SRCA and peacetime applications under MRCA – see Sections 6.2 and 6.3 below. At a "reasonable hypothesis" standard, the SoP 'details the factors that must as a minimum exist and which of those factors must be related to service rendered by a person, before it can be said that a reasonable hypothesis has been raised connecting an injury, disease or death of that kind with the circumstances of that service'.

The level of impairment is then estimated using the Guide to the Assessment of Rates of Veterans' Pensions (GARP V).²⁰ The GARP has sections for assessing impairment to produce one overall impairment rating on a point scale from 0 to 100 ('impairment points').²¹ It does this across a range of conditions, using different assessment templates for the particular condition. One template exists for example, for the emotional and behavioural consequences of accepted psychiatric conditions. GARP also assesses how that particular medical condition(s) affects the veteran's lifestyle. GARP then converts the impairment points and the lifestyle rating into a percentage which is the percentage of General rate pension for which the veteran is eligible.

Disability pensions are not taxed and exist for life. A disability pension is not counted as income for the service pension income test.

As stated, the main purpose of the VEA has been to provide military compensation for military injuries/disease in war and warlike/peacemaking activities. It has not aimed to provide rehabilitation though the Veterans Vocational Rehabilitation Scheme (VVRS) was recently introduced to provide this opportunity. The VVRS has however a low participation rate among TPI pensioners.

¹⁹ Repatriation Medical Authority 2000-1 Annual report

(http://www.rma.gov.au/pubs/annual_report_2001/function.htm - accessed Jan 14 2009)

²⁰ Department of Veterans' Affairs. Guide to the Assessment of Rates of Veterans. Pensions 1998
(<http://www.vrb.gov.au/pubs/garp-title.pdf> - accessed Jan 14 2009)

²¹ Minister for Veterans' Affairs Military Rehabilitation and Compensation Act 2004

Guide to determining impairment and compensation explanatory statement

(<http://209.85.173.132/search?q=cache:rZ7IqAbbWf8J:www.comlaw.gov.au/ComLaw/Legislation/LegislativeInstrument1.nsf/0/91949ABB60DDEB83CA25701B00186AFD/%24file/Guide%2Bimpairment%2BCompensation%2B21%2BJune%2B2004%2BEx%2BStatement.doc+impairment+lifestyle+veteran+vea&hl=en&ct=clnk&cd=2&gl=au> - accessed Jan 14 2009).

DVA disability pensioners may also receive an Invalidity Service Pension (which is subject to an asset and income test in which the DVA pension though is not counted as income), superannuation through Military Superannuation (Mil Super) or the Defence Force Retirement & Death Benefits Fund (DFRDB).²²

6.2 The Safety Rehabilitation and Compensation Act

The Safety Rehabilitation and Compensation Act (SRCA) (1988) replaced the Compensation (Commonwealth Government Employees) Act 1971.²³ It is the Commonwealth's workers' compensation legislation that applies to all employees of the Commonwealth, not just members and former members of the ADF. From 1988 to 1994, it provided workers compensation for peacetime activity in the ADF. From 1994 it offered as well compensation for war-like (operational), non war-like (peacekeeping, hazardous) or peacetime (full-time and part-time) service. Like the VEA, it was also replaced by the Military Rehabilitation and Compensation Act (MRCA) in July 2004. Nevertheless, it continues to operate for eligible claims originating before July 2004. (3,327 SRCA claims compared with 32,287 VEA and 2,450 MRCA in 2007-8).

It provides a lump sum payment as compensation for permanent impairment (including for pain and suffering). It also provides a weekly incapacity payment (for loss of income) which ceases at 65 and is subject to review – and thus may fluctuate over time. VEA-derived pension payments are reduced by SRCA payments.

Being a workers' compensation scheme, a central objective of the scheme is rehabilitation and Return to Work. Rehabilitation is provided by Approved Rehabilitation Providers through ComCare. It is thus very different in its aims to the VEA.

The principal differences between SRCA and VEA are set out in the table over for other than death benefits (same reference as Footnote 15).

6.3 The Military Rehabilitation and Compensation Act

As noted, the Military Rehabilitation and Compensation Act (MRCA) was introduced in July 2004 to replace the VEA and SRCA and to cover all military service - warlike non-warlike and peacetime. It supports a scheme offering both military compensation and workers compensation and offers the existing benefits of both schemes.²⁴ More specifically, like SRCA, it provides a lump sum payment as compensation for

²² A Centrelink Disability Support Pension may also be sought by the veteran in the event that their application for veterans' compensation is unsuccessful.

²³ Department of Veterans' Affairs DVA Facts MCS02 Military Compensation – Safety Rehabilitation and Compensation Act 1988 (SRCA) Comparison of the Safety, Rehabilitation and Compensation Act 1988 and the Veterans' Entitlements Act 1986 (<http://www.dva.gov.au/factsheets/documents/MCS02%20Comparison%20of%20SRCA%20and%20VEA.pdf>- accessed Jan 14 2009).

²⁴ The Military Rehabilitation and Compensation Commission (MRCC) is equivalent to the Repatriation Commission in being the statutory body approving veterans' compensation under the MRCA.

permanent impairment (including for pain and suffering). It also provides a weekly incapacity payment (for loss of income) up to 75% of normal earnings which

VEA	SRCA
No lump sums	Lump sum for Permanent Impairment – offset with VEA – tax free
Disability Pension – tax free – continues beyond age 65	No pension
No income maintenance – but Loss of Earnings allowance and Temporary Incapacity allowance are available	Weekly Incapacity payments – taxable – subject to review – cease at age 65 – offset with VEA and Superannuation
Service Pension – income and asset tested – payable at age 60 (male)	No
Rent Assistance – subject to rent threshold and income test	No
Remote Area Allowance	No
Attendant allowance	Attendant Care Services
Household services – some through the Veterans' Home Care program	Household services
Vehicle Assistance Scheme – modification & maintenance	Vehicle modifications only as assessed by Occupational Therapist
Recreation Transport allowance	No
Travel cost reimbursement if attending medical appointments	Travel cost reimbursement for medical treatment, trip must be min. 50km return
Clothing allowance	No
Telephone allowance	No
Medical Treatment – White or Gold treatment card – Aids and appliances	Medical Treatment – No cards – Direct payment for or reimbursement of reasonable medical treatment for compensable condition – Aids & appliances – reasonable costs
Pharmaceutical allowance	No specific allowance but reimbursement of reasonable costs as per medical treatment.
Rehabilitation – through the Veterans' Vocational Rehabilitation Scheme	Vocational Rehabilitation
Home modifications No workplace modifications	Home and Workplace modifications – reasonable costs as identified by an Occupational Therapist.

ceases at 65 and is subject to review – and thus may fluctuate over time. The Military Rehabilitation and Compensation Commission (MRCC) has issued a guide called the Guide to the Assessment of Rates of Veterans' Pensions V, Modified, referred to as GARP V(M).²⁵ The guide is the same as the GARP that is used in the VEA but with

²⁵ The Military Rehabilitation and Compensation Scheme. Plain English Guide to the Military Rehabilitation and Compensation Act 2004 (http://www.rslqld.org/Portals/0/Pensions%20Documents/PLAIN_ENGLISH_GUIDE_TO_MRCA.doc - accessed Jan 14 2009).

changes to the way impairment and lifestyle ratings are combined to determine compensation payable.

However as an alternative to the impairment lump sum, it offers a weekly payment tax-free for life (or a mix of the two). As an alternative to the weekly incapacity payment, it offers a Special Rate Disability Pension (SRDP) (The Safety Net) equivalent to the TPI. It thus has dual tracks matching the SRCA or VEA respectively. While this increases choice, it also increases complexity.

Similar to SRCA, MRCA has, as a central objective the provision of rehabilitation aimed at Return to Work. Needs Assessment for rehabilitation is made following Assessment for Liability. Rehabilitation again is provided by Approved Rehabilitation Providers through ComCare.

The SDRP, unlike the TPI, offsets payments for permanent impairment and employer contributions to superannuation.

The Military Compensation and Rehabilitation Group (MRCG) was established in DVA in 1998. This occurred when responsibility for SRCA transferred from the Department of Defence to DVA which then became responsible for not only VEA (which had always been with DVA) but SRCA as well.

6.4 The DVA decision making process

A veteran with multiple disabilities may make a number of applications (for different disabilities) to more than one scheme, with one application (not more) for each particular disability.

From the veteran's point of view, this can become very complicated given that they may need to make separate application for superannuation (Mil Super or DFRDB to ComSuper), an Invalidity Service Pension (to DVA) or even for a Disability Support Pension (to Centrelink) if, for example they are concerned that there will be a delay in the decision to approve their other claims.

From the DVA delegate's point of view, they will need to consider the veteran's application under any of three schemes or in fact a combination of two or three of them. In either case, the delegate will need to have knowledge of each of the three schemes to make a decision.

The delegate will consider whether the material presented in the veteran's application establishes to a "reasonable hypothesis" or "balance of probabilities" standard (as relevant). Steps to establish a service connection to a "reasonable hypothesis" standard are:

- the diagnosis of the injury/disease;
- the time of its clinical onset;
- its connection to service;
- identification of the hypothesis raised by material presented;
- the identification of the relevant SoP;

- testing whether the hypothesis is reasonable against that SoP; and whether
- material exists which could disprove the hypothesis.

This is usually straightforward but where it is not, the delegate will consult their team leader and possibly a Repatriation Medical Officer, especially in the unusual case that a SoP does not exist for a particular disease.²⁶ Considerable time may be spent in making a decision not to accept a veteran's application.

The delegate receives initial assessor training over a 6 month period. This will consist of initial classroom training for 2-4 weeks, assessment tasks under mentor supervision for one month, assessment tasks with access to the mentor for two months. After this four month period, they will receive internal accreditation as an assessor and acquire a caseload. They will however be audited for a further two months by a Quality Assurance officer, the frequency of audit depending upon their error rate. At six months, they will become an independent assessor accountable to a team leader. Assessors are also likely to have prior DVA experience other than as an assessor.

By the nature of their role, a delegate will need to be able to balance the interests of the veteran but also the Government through DVA, as the custodian of public monies.

6.5 The appeal process

In the event that the decision is not to approve the application by the delegate after consultation, the veteran is able to make an application for review of this decision.²⁷ This can be sought through a departmental review (eg Section 31 under the VEA). While such a review may lead to a decision more favourable to the veteran than the initial one, it is also possible that the review may lead to a decision less favourable to veteran.

It can be sought through application to the Veterans Review Board (VRB) for VEA and MRCA but not SRCA schemes. In this event, Section 137 of the VEA requires DVA to provide a claimant and the VRB with a report of the evidence considered in a primary claim within 42 days of the Department receiving a VRB application from the veteran. While veterans can receive legal advice in preparing their application to the VRB, they can not be represented by lawyers there. Rather, they may represent themselves. Very frequently, an Advocate, a volunteer trained by an Ex-Service Organisation (ESO) has assisted the veteran both in the preparation of the application and may represent them before the VRB.

DVA lawyers prepare the Section 137 application to the VRB and also the DVA position to the AAT (see below). DVA uses a panel of lawyers on contract for MRCA cases.

As stated on their webpage, the VRB 'is an independent tribunal that exists to review:

²⁶ The Repatriation Medical Officer is more usually consulted to interpret an ARP rating of impairment made by the veteran's GP or specialist (not lifestyle) or to clarify clinical aspects of the veteran's medical condition and its reporting by their doctor.

²⁷ A review can also be sought where an application for upward variation to an existing level for an approved pension is rejected.

- decisions made by the Repatriation Commission under the Veterans' Entitlements Act 1986 (Cth) on: claims for acceptance of injury or disease as war-caused or defence-caused;
- determinations under the Military Rehabilitation and Compensation Act 2004 (Cth) made by the Military Rehabilitation & Compensation Commission; and the Service Chiefs of the Australian Army, the Royal Australian Navy, and the Royal Australian Air Force.²⁸

Most cases are reviewed by a panel of 3 members - a Senior Member, a Services Member and one other Member from a pool of over 40 members. Sometimes two members will review a case if the third member is ill or unavailable. Senior Members are usually lawyers and they preside at hearings. Services Members are selected from nominations submitted to the Minister for Veterans' Affairs by Ex-Service Organisations. Other Members have a wide variety of qualifications. In making its determination, the VRB must apply the law as set out in either the VEA or MRCA, whichever is relevant to that case.

Appeals can also be made to the Administrative Appeals Tribunal (AAT) where the veteran can be represented by lawyer.²⁹ Applications can also be made to Higher Courts but only on points of law.

Not all primary decisions, made against the veterans proceed to review or appeal. A proportion of those that do proceed however are overturned. Numbers for 2007-8, going to appeal as well as overturned are set out in the table below.

Appeal type	Scheme	Number of claims	Number (%) of successful claims	Did not appeal	Appeal	Proportion overturned
VRB						
	VEA	32,297*	19,695 (61%)	7,903	4,689	2,001 (43%)
	MRCA	2,450	80% (est)	2,414	36	13 (36%)
	SRCA	3,327	Not known	Not Rel	Not Rel	Not Rel
Section 31						
	VEA	32,297*	19,695 (61%)	Not known	NK	NK
	MRCA	2,450	80% (est)	2143	307	102 (33%)
	SRCA	3,327	Not known	Not known	350	97 (28%)
AAT						
	VEA	32,297*	19,695 (61%)	Not known	NK	NK
	MRCA	2,450	80% (est)	2,426	24	8 (33%)
	SRCA	3,327	Not known	Not known	238	110 (46%)

* 24,474 veterans;

VEA appeals constitute almost all reviews to the VRB. MRCA has a higher proportion of successful claims than VEA. It also has somewhat fewer appeals overturned at the VRB, than the VEA.

²⁸ Veterans' Review Board (<http://www.vrb.gov.au/> - accessed 14 Jan 2009)

²⁹ DVA may conduct its own review of a VRB or AAT decision.

An internal DVA review of overturned cases in NSW was conducted for the years 2002-5.³⁰ It indicated that around 85% of cases were set aside wholly or partly on the basis of the presentation of new evidence rather than delegate error. Some additional evidence may come about because of changes in the severity of the disease over the passage of time. It was reported that at least half of the General Pension decisions set aside, involved a change of only 10% increase in the General rate pension percentage level. Delays in hearing appeals before the VRB seemed to be more associated with delays at the VRB than the DVA. The latest available VRB's Annual report (2006-7) indicated that 37% of outstanding cases before the VRB were more than 12 months old.

6.6 The Client Liaison Unit

The Client Liaison Unit (CLU) manages relationship with clients in complex cases and relationship breakdown under all three Acts. It provides a single point of entry and ongoing contact mainly by telephone. Staff members in the CLU have no delegation powers but are able to liaise with delegates and other parts of DVA and act as advocates for the veteran including to expedite decisions. The staff member can thus explain and discuss the status of the application process and any decision made with the veteran.

Staff make clear they are not counselors. They have DVA backgrounds and have attended short training courses such as ASIST. They have ongoing contact with VVCS and psychologists in DVA and access to an Employment Assistance Program on a 24-hour basis. A second staff member is involved in each phone call, for note-taking, debriefing and 'backup' contact with the veteran in the absence of the principal staff member. Staff need to exercise a duty of care as clients very frequently, at some point in their telephone calls threaten self-harm or harm to others. Processes are in place for both circumstances.

The CLU is well regarded in DVA and has an ongoing role. A multivariate mathematical model for factors predicting CLU use is being developed.

6.7 The High Needs Case Management Pilot

The High Needs Case Management Pilot (HNCMP) program operated in 2007 as an initiative of the DVA Sydney Office. It involved only that group of the DVA administering the MRCA scheme (that is to say it operating one of the three Acts). Unlike the CLU, staff members did have delegation powers. Three case managers each took on a caseload of 40 clients with multiple needs, as their single point of contact with DVA. These case managers were very suitable, as they had both DVA assessor background and health care provider experience.

Many of the cases were complex involving psychological conditions, physical injuries, dual entitlement and ongoing contact with the Minister's Office. Contact with clients is intensive, often on a daily basis and clients can be abusive. The role as case manager is consequently emotionally demanding and it was important that these staff members receive advice, an opportunity to debrief and support from a group

³⁰ Koop G, Department of Veterans Affairs, pers comm.

such as VVCS. As soon became apparent, the work of the case managers did not confine itself to MRCA claims but, through dual entitlements, quickly extended to include other Acts.

An internal evaluation of the HNCMP was conducted based on Before (32 clients) and After (37 clients) surveys of the client group.³¹ It indicated that:

- A good or excellent rating of satisfaction with the level of service of the MRC group increased from 31% to 51%;
- An excellent rating of experience with staff increased by 30%;
- A satisfactory or easy rating for accessing information increased from 59.5% to 92%;
- Overall clients' awareness of services had increased;
- Nearly half of the clients indicated that their level of service had increased;
- Many clients still felt that their claims were not dealt with in a timely way;
- 72% of respondents had only one case manager;
- The level of complaints against MRCA group in the NSW branch of DVA reduced from 27 to 13 per month.

6.8 The post-HNCMP work of the national MRCA group

In spite of the positive evaluation findings of the High Needs Case Management Pilot, it did not continue into 2008. This was largely due to concerns about the impact on staff of working in the very emotionally demanding role of the 'multiple-needs' case manager. A different approach with the same intent was therefore implemented. Rather than have a few case managers dedicated to clients with complex needs, it was proposed that all staff manage all clients according to their needs. Clients are now being triaged according to their needs, case priority and potential applicability under other schemes. Case priorities are established on factors such as death, severe injury, being an ADF member transitioning-out on medical grounds, unemployed, hospitalised or in need of urgent medical attention.

If the injury is predictable and there is low risk being associated with accepting liability, there may be very little client contact. Alternatively, if the client has multiple needs, a more case management approach and close contact will be needed. Other approaches are being considered – for example, should all mental health claims be managed in a different way, bearing in mind they do not all necessarily fit into the complex multiple-needs group.

More generally, the group aims to introduce this needs-based approach alongside new client service goals, both being monitored with Key Performance Indicators.

Rollout is complicated by other developments in DVA involving greater integration of the three compensation schemes. At present, VEA and MRCA claims are processed in isolation of each other, making it difficult to detect if the same disability is claimed under different schemes. This will continue until the new DVA mainframe computer is installed in 2009-10.

³¹ Clark S (2007) Military Compensation Pilot Project Sydney: A Case Management Approach for Clients with Multiple Needs. Final Report. Department of Veterans Affairs: 1-12.

In addition, the Single Claim Form for the three veteran compensation schemes is due for implementation in first half of 2009 – see Section 6.11.2 below. The Separation Health Examination form is also currently being trialled in Canberra and Wagga, for members medically discharging from the ADF – see Section 5.7. The Separation Health Examination form will include all medical reports and information and constitute a claim form for both DVA and ComSuper. It is hoped there will be little need for additional specialist medical reports.

6.9 DVA operations

DVA has reorganised in the last few years and operates less as State-based offices responsible for the organisation and delivery of all functions in their jurisdiction. The organisation of many functions now occurs on a national basis but is located in a particular State Office.

In addition DVA is undergoing changes as its client base of veterans from earlier conflicts die. This impacts on DVA's annual budget allocation and occurs alongside normal governmental searches for cost-efficiencies in departmental expenditures. Many DVA staff have taken early retirement. Delegates are reported to have very heavy caseloads. There are ongoing difficulties for them in having to make decisions in relation to three compensation schemes, sometimes two or three schemes together in the same client. MRCA, which incorporates features of both VEA and SRCA, including each of their arrangements for impairment and/or incapacity payments, is particularly complex.

The ESOs as peak bodies and advocacy groups for veterans take a keen interest in DVA affairs given that DVA's principal role is to provide services to veterans. This is a natural and valuable role for the ESOs.

As noted, VEA and MRCA schemes operate independently of each other though this will end in 2009-10 with the introduction of the DVA mainframe computer. The operations of ComSuper and Centrelink though will continue to operate independently of DVA operations (except through their involvement in the Inter Departmental Working Group).

6.10 Study into barriers to veterans' social and occupational rehabilitation

As part of the Australian Government Mental Health Lifecycle Initiatives for Veterans and Former Serving Members, the Australian Centre for Posttraumatic Mental Health (ACPMH) has been contracted by DVA to undertake a 'Study into Barriers to Rehabilitation which is primarily focussed on DVA clients who receive services under the Military Rehabilitation and Compensation Act (MRCA). The research will consider whether there is evidence of systematic barriers (particularly those that DVA may be able to redress) and individual barriers to successful rehabilitation for DVA clients.

6.11 Experience from other countries

The UK and Canada have veterans' compensation schemes similar to SRCA and the pathway in MRCA that emulates SRCA.

UK

As stated on the Ministry of Defence's website, the Armed Forces Compensation Scheme has been recently introduced and replaced an earlier scheme.³² It provides a lump sum award (in four bands) for pain and suffering for significant qualifying injuries and illnesses.³³ Larger payments will go to the more seriously disabled. It takes into account the expected level of deterioration. It also offers a tax-free Guaranteed Income Payment (GIP) for life for those at the higher levels of the tariff (1-11) to compensate for loss of earnings capacity. The value of the income payment is set at different levels, dependent on the expected degree of lost earnings capacity caused by the disablement.

It is run by Service Personnel & Veterans Agency (SPVA) administrators with access to specialist medical advice. The Scheme uses the "balance of probabilities" standard of proof, in line with similar schemes for civil claims. There is no regular review mechanism. Awards are, in general, full and final with provision for interim awards where the long-term prognosis is unclear and for review in exceptional cases where significant unexpected complications arise. There is an internal review process and an independent appeals process using the Pensions Appeal Tribunal and Social Security Commissioners as well as higher courts of law.

These compensation benefits are in addition to those non-attributable benefits under superannuation (pension) payments on medical discharge or death-in-service. There is though a "netting off" to avoid double compensation eg for loss of earnings capacity. Any injury, illness or death which is linked to events prior to its introduction in 2005 will continue to be dealt with under the War Pension Scheme and the Armed Forces Pension Scheme 1975.

Canada

Veterans Affairs Canada (VAC) has recently introduced a dual award approach toward compensation. As stated on their website, one element of this dual-award approach is the disability award.³⁴ It recognises and compensates Canadian Forces (CF) clients for non-economic effects of service-related disability, including pain and suffering, functional loss and the effects of permanent impairment on their lives and

³² Ministry of Defence UK Key features of the Armed Forces Compensation Scheme (AFCS) (<http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/Personnel/Pensions/ArmedForcesPensions/AFCS/KeyFeaturesOfTheArmedForcesCompensationSchemeafcs.htm> - accessed 16 Jan 2009).

³³ Veterans UK Pensions Compensation Armed Forces Compensation Scheme (AFCS) (<http://www.veterans-uk.info/pensions/afcs.html> - accessed 16 Jan 2009).

³⁴ Veterans Affairs Canada (VAC) New Veterans Charter - Questions & Answers (<http://www.vac-acc.gc.ca/clients/sub.cfm?source=Forces/nvc/newqa#a03> - accessed 16 Jan 2009)

the lives of their families. The award is paid as a tax-free lump sum payment. Awards will range from 1% to 100% calculated in increments of 5%, with a maximum award for a 100% disability.

The second element of the dual-award approach is the Earnings Loss program. It will compensate for the economic impact that a service-related or career-ending condition has on a CF Veteran's ability to earn a living. The two programs will operate independently. There will be no offsetting of benefits between them.

The lump sum award has to be considered in the context of the overall suite of new programs. Under the new approach, eligible CF Veterans will be offered a comprehensive range of benefits and services not available to them under the present scheme. The programs of the New Veterans Charter will consist of Rehabilitation Services, Vocational Assistance, Health Benefits, Job Placement Assistance, Financial Benefits (Earnings Loss, Supplementary Retirement Benefit, Permanent Impairment Allowance, and Canadian Forces Income Support) as well as the disability award.

Previously in Canada under the Pensions Act monthly pension existed instead of the lump sum payment for non-economic effects of service-related disability. Generally most applications for disability benefits received after the coming-into-force date will be processed as a (lump sum) disability award.

In introducing the new system, Veterans Affairs Canada (VAC) examined the current practices of Veterans Affairs Departments in Australia and the UK as well as provincial Workers Compensation Boards and Canadian courts through personal injury awards.

The US, by comparison has a graduated pension scheme similar to VEA

6.12 Assessment

This overall assessment is based on a review of all technical and research documents, stakeholder input and public submissions. A summary of themes arising out of both individuals and organisation submissions relevant to *Veteran compensation schemes and mental health* are included in Appendix 1.

6.12.1 Veterans and their dealings with DVA

There were many reports of frustration and anguish among veterans and their families in dealing with the DVA in the public submissions. These are probably inevitable during the period when the claim has not been decided or the outcome did not turn out as anticipated. DVA has a difficult job to process a large number of claims and do so with constrained staff numbers. Nevertheless, long delays in processing some claims and accompanied by little communication with claimants still occurs despite recent improvements in KPIs for timeliness in processing claims.

As noted in Section 6.5 above, delays may also be associated with long delays in the conduct of VRB tribunal hearings. They may also be associated with assembling all of the veteran's relevant ADF medical history and receiving all of the veteran's medical specialist reports. The latter may involve correspondence between DVA and the

medical specialist for further information that would support the veteran's claim. There may be delays in receiving both initial and any subsequent reports from these specialists. In the event that this further information is not provided, DVA may request the veteran to attend another specialist so as to obtain it.

It was reported that while some DVA delegates are excellent communicators, others less so. There was one report from a senior DVA officer of low morale among junior DVA staff members, including delegates. As noted, delegates and DVA staff more generally need to balance the interests of the veteran and the Government, through DVA, as the custodian of public monies. Staff may have views about the level of veteran compensation (and fraud) and these have the potential to affect staff attitudes. They are discussed further in Section 7. Veterans who have represented their country at war however are entitled to expect respect and empathy. Furthermore, a strong orientation to client service is now a feature of all modern public and private human service organizations.

6.12.2 Complex schemes and complex cases

It is widely recognised that the three military compensation schemes are difficult for veterans to navigate and DVA delegates to advise and process. This is made more difficult again since veterans may be eligible for non-compensation-related income maintenance through:

- superannuation (Mil Super and DFRDB through ComSuper);
- service pensions (Invalidity Service Pensions through DVA); and
- other government income support payments (Disability Support Pension, Newstart and Sickness Allowances through Centrelink).

The operation of MRCA and veterans' compensation more generally will be reviewed in 2009. The reviewer may well feel obliged to carry forward the features of both military compensation and workers compensation in MRCA and do it without detriment to existing benefits. It is not clear if it is possible to remove the two track processes that exist in MRCA, again without detriment to existing benefits. It would simplify the scheme considerably if this could be done. It is also not clear if it is possible to roll-up VEA, SRCA, MRCA into a successor scheme so that only one scheme exists and again do this without detriment to the existing benefits that a veteran would otherwise be entitled to obtain under existing arrangements.

It is worth noting that Canada and US essentially now have one scheme only operating and the UK one present and one past scheme operating. The former two have recently moved to new schemes both with impairment-linked lump sum and incapacity-linked pension components (similar to SRCA). As noted, the US has a graduated pension scheme similar to VEA. With the immanence of the review and its specialised nature, it is not useful to make further comment on the three schemes.

As noted, 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. Again, as noted, separate IT systems exist within DVA and across government departments making processing of application for veteran compensation and other benefits more difficult at least for some time.

The Inter Departmental Working Group within Defence Links with core membership of DVA, DoD with ComSuper, Centrelink and FaCHSIA, joining more recently has been seeking administrative simplification of the three Acts within its remit to make it more possible for a member to transition-out of the ADF as seamlessly as possible.

These include, as noted:

- the Single Claim Form for all three compensation schemes to be introduced in the first half of 2009; and
- the Separation Health Examination for members transitioning out of ADF on medical grounds is (currently being trialed in Canberra and Wagga). The form brings together all medical information and reports and will serve as both a DVA and ComSuper claim form.

The Client Liaison Unit which operated across all three Acts though without delegate powers appears very successful. The High Needs Case Management Pilot established initially to process MRCA claims and with delegate powers also proved very successful as the results of its internal evaluation study strongly indicate.

It has not been continued though the changing business processes of the MRCA group nationally represent a welcome development. This includes a more needs-based and client-centred approach to veteran's compensation claims.

There seems some uncertainty about the extent to which they will be fully implemented. In any event they only apply to MRCA-related work which represents only about 6.5% of veteran compensation claims currently (though this will increase in the future). These needs-based initiatives with a differentiated, more intensive approach with features of case management for complex, multiple needs clients need to be implemented. This should occur within VEA very importantly but also within SRCA. They should preferably also exist for claims involving multiple Acts.

The best method of delivering these case management approaches to veterans who have complex and multiple needs is not clear. The new business approaches of the MRCA group should be implemented and evaluated. There is no reason to hold back on the introduction of case management approaches, with further evaluation, within the VEA group. This could take the same or different form to what is happening in the MRCA group.

Whatever the value of case management approaches, there can be no debate about the importance of a strong service orientation in dealings with clients. This should be introduced and its implementation monitored without delay.

Veterans submitting mental health-related claims whether primary or on appeal, for a variety of reasons may both face difficulties in submitting claims and react negatively to delays and setbacks. In the worst possible case this can manifest itself in self-harm.

As noted in Section 6.5 above, a significant proportion of primary claims for compensation not accepted by DVA go to review under Section 31, VRB or AAT are not affirmed and this may be accompanied by considerable delay. This can lead to considerable distress for the veteran, particularly when it is accompanied by little communication about the progress of their appeal – see Section 6.10.2. As also noted

in Section 6.5, the reason that many of the reconsidered claims were not affirmed was due to more complete information being submitted at the review than at the initial submission.

6.12.3 Appeals, delays and distress

If the reason that a veteran's valid claim fails is so frequently that it supplied incomplete information, DVA could consider a further step in the primary application process whereby the application could be returned to the veteran indicating areas where further supporting documentation is the necessary. This would be separate and different in nature to a Section 31 review. While this adds another step in the application process and have cost and staff consequences, this should be offset by reduction in cost and staff time in Section 137 applications and preparation of case material and appearances at AAT appeals.

The Veterans Review Board in general works well with independent and eminent members, many nominated by ESOs. It is surprising however that a tribunal that is not adversarial in its approach and excludes lawyers from representing veterans, is so oriented to the law. First, Section 137 material is prepared by DVA legal staff or contract lawyers. Second, almost half of VRB members have legal backgrounds. This is bearing in mind veterans will either be unrepresented or if they are represented, will be represented by a volunteer advocate from an ESO.

By contrast only a few VRB members have mental health, counseling or even medical backgrounds. This is surprising given that the VRB is asked to reconsider the medical and mental health material based upon the application of epidemiology and evidence-based medicine in the form of the SoPs. It is important to appreciate the strengths but also the discretion needed in the interpretation of the SoPs and their application. This will be difficult for a person with a non-medical or non-clinical background.

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.

The role of advocates and ESOs more generally in supporting veterans in appeals as well as initial applications is discussed further in Section 7.

6.12.4 Claims involving chronic mental conditions

A separate process for mental health claims should be established involving formal consultation with an appropriate mental health professional (psychiatrist or clinical psychologist with College of Clinical Psychology membership) to assess the mental health impact of DVA decisions on veterans with chronic mental conditions at all important decision points (eg primary claims, Section 31 and where relevant, VRB and AAT appeals, as well as suspension and downgrading of benefits and CDDA applications). This will be further discussed in Section 7.4 in relation to historical investigation of the veracity of exposure to a Category 1 Stressor. To do this, DVA will need to increase its capacity to access psychiatric/clinical psychological advice for both individual cases and policy more generally.

A further complication for veterans with chronic mental conditions is that they do not always move towards a state of permanent impairment. They often follow a more fluctuating course of deterioration and improvement eg PTSD and depression.³⁵ This means that there may be considerably delay before they become eligible for permanent benefits for either impairment or incapacity. Thus a veteran who experiences a deterioration of their condition will become eligible to move from a General disability pension to a Temporary Special Rate pension but not a permanent Special Rate pension. Mental illness is not unique in this - it may happen with physical illnesses such as multiple sclerosis. It means though they will need to be reassessed after a 6-month period and possibly beyond. This financial uncertainty can be very stressful to a veteran with a chronic mental condition, indeed any chronic condition.

A capacity to extend the period of the Temporary Special Rate pension (or equivalent) should exist. This would require the veteran's doctor to provide robust evidence of a level of patient distress, or risk of self-harm sufficient to render dangerous the conduct of a GARP(V) assessment of impairment and lifestyle. In the event that there the veteran does not have a doctor able to provide this robust evidence, a representative of the veteran would be required to provide a similar level of robust evidence. Either a limit of the period of extension would have to exist or alternatively, the veteran would move automatically from a temporary to a permanent Special Rate pension after a specified time period.

6.13 Recommendations

Recommendation 6.1: Initiatives such as the Single Claim Form, Separation Health Examination and the Client Liaison Unit are valuable and, subject to satisfactory trialing can be strongly supported.

The changing business processes of the MRCA group including a strong orientation to client-service are welcomed but should extend to all three schemes, particularly the VEA group and be further strengthened with business, training and evaluation plans.

Experienced case managers should be assigned to claims of clients having complex multiple needs claims.

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

It is desirable that the period of the Temporary Special Rate pension (or equivalent) can be extended if the veteran's doctor (or in the event that a doctor is not able to do

³⁵ Committee on Veterans Compensation for Posttraumatic Stress Disorder, Institute of Medicine and National Research Council (2007) PTSD Compensation and Military Service The National Academies Press, Washington, 1-249:9.

this, a representative of the veteran) can provide robust evidence of a level of patient distress or risk of self-harm sufficient to render dangerous the conduct of a GARP(V) or GARP(V) M assessment of impairment and lifestyle.

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

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

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

Section 7 PTSD and compensation

7.1 Introduction

A number of people believe that many veterans making applications for PTSD are unduly influenced by consideration of generous compensation pension and benefits. This is further bearing in mind that these often come on top of disability-related superannuation and service pension payments. This view is expressed not only in Australia but other countries as well.

In the US, this view has been influenced first, by reports of very large recent increases in the number of veterans receiving disability pension payments. Thus, from 1999 to 2004, the number of veterans receiving VA disability payments in the US for PTSD increased 79.5% (from 120,265 to 215,871), whereas those receiving payments for other disabilities increased only 12.2%.³⁶

Second, rates for PTSD in the US are now very high. Thus, the National Vietnam Veterans Readjustment Study (NVVRS) of a representative sample of 1200 veterans in 1988 estimated that 30.9% had developed PTSD during their lifetimes and that 15.2% were currently suffering from PTSD.³⁷

In Australia, DVA TPI disability rates for PTSD are also high. 17,442 (29%) of the original 60,220 Vietnam veteran cohort have received TPI pensions - 10,600 (21.6%) of 49,000 surviving Vietnam veterans.

The significance of all this is that such perceptions have the potential to influence both clinicians and others in decision-making. This has sparked a very lively debate which is set out at length below.

7.2 Does compensation hinder recovery from PTSD?

Frueh et al (2007) referred to above, have published a controversial article in which they put the argument strongly that current VA disability policies in the US are counter-therapeutic and require fundamental reform to bring them into line with modern science and medicine, including current empirically supported concepts of resilience and psychiatric rehabilitation. They assert that:

- ‘recent, more rigorous estimates of PTSD prevalence among Vietnam War veterans are about 40% to 65% lower than original estimates, and there may be proportionally few cases of severe functional impairment in veterans with PTSD’;
- ‘many treatment-seeking veterans (53%), especially those seeking disability compensation, show clear symptom exaggeration or malingering on psychological tests and forensic interviews’;

³⁶ Frueh BC Grubaugh AL, Elhai JD et al (2007) US Department of Veterans Affairs Disability Policies for Posttraumatic Stress Disorder: Administrative Trends and Implications for Treatment, Rehabilitation, and Research. *Am J Public Health*. 97:2143–2145.

³⁷ Dohrenwend BP, Turner JB, Turse NA et al (2006) The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods *Science* 313: 979-982.

- ‘veterans with a PTSD diagnosis benefit far less from treatment compared with other patients with PTSD (e.g., rape victims). A recent meta-analysis found that 67% of the patients who completed psychotherapy for PTSD no longer met criteria for the disorder at post-treatment, but little evidence of efficacy was found among veteran samples’.

These conclusions have been disputed by Marx et al (2008). They argue that studies exist, and not cited by Frueh et al showing that:

- ‘rates of mental health service use increase among veterans who receive VA disability benefits for military-related PTSD;
- medical and mental health service use increases after filing a disability claim compared with the pre-application period,
- engagement with mental health services is sustained after claim determination for veterans whose disability-related claims are approved and
- treatment outcomes are comparable between outpatient veterans who seek or receive disability compensation relative to those who do not.’

In addition, they argue that Frueh et al are selective in their coverage in presentation of issues concerning malingering. Although they cite extensively from the 2005 report of the VA inspector general, they fail to acknowledge that the same report found that only 13 of 2100 (0.6%) service-connected PTSD cases, subjected to detailed review were deemed to be potentially fraudulent.

Furthermore, Marx et al argue that Frueh et al’s suggestion that over half of treatment-seeking, especially compensation-seeking veterans exaggerate symptoms or malingering on psychological tests is based on a small unrepresentative sample and uses a measure of malingering not validated outside forensic settings. In addition, previous research suggests that exaggeration may be as much a sign of severe distress and psychiatric comorbidity in PTSD sufferers, as malingering.

Dohrenwend et al (2006) conducted a very careful study of the National Vietnam Veterans Readjustment Study (NVVRS) and estimated PTSD rates noted in Section 7.1 above.³⁸ They ‘used military records to construct a new exposure measure and to cross-check exposure reports in diagnoses of 260 NVVRS veterans. They found little evidence of falsification, an even stronger dose-response relationship, and psychological costs that were lower than previously estimated, but still substantial. According to their fully adjusted PTSD rates, 18.7% of the veterans had developed war-related PTSD during their lifetimes; 9.1% were currently suffering from PTSD 11 to 12 years after the war; and current PTSD was typically associated with moderate impairment.’

In this disputed situation, it is worthwhile to consider the conclusions of an authoritative report on *PTSD, Compensation and Military Service* by the US Institute of Medicine and National Research Council on these matters.³⁹ They state that

³⁸ Dohrenwend BP, Turner JB, Turse NA et al (2006) The Psychological Risks of Vietnam for U.S. Veterans: A Revisit with New Data and Methods *Science* 313: 979-982.

³⁹ Committee on Veterans Compensation for Posttraumatic Stress Disorder, Institute of Medicine and National Research Council (2007) *PTSD Compensation and Military Service* The National Academies Press, Washington, 1-249:9.

‘In summary, while misrepresentation of combat involvement and exposure undoubtedly does happen among veterans seeking treatment and compensation for PTSD, the evidence currently available is insufficient to establish how prevalent such misrepresentations are and how much effect they have on the ultimate outcome of disability claims. And no matter how common such behaviour ultimately proves to be,’ ... ‘the most effective strategy for dealing with problems with self-reports of traumatic exposure is to ensure that a comprehensive, consistent, and rigorous process is used throughout the VA to verify veteran-reported evidence.’

Nevertheless, more research as well as more rigorous assessment processes are needed. For example, there is the observation of Marx et al (2008) above that exaggeration may be as much a sign of severe distress and psychiatric co-morbidity in PTSD sufferers as malingering. Rigorous assessment processes will need to take this phenomenon into account. Even while Frueh et al (2007) argue that some veterans misrepresent combat exposure or war-zone deployment, they concede some veterans’ reports of combat exposure change over time as a function of reported PTSD symptom severity.

7.3 The SoPs, evidence-based methods and rigorous assessment procedures

Donald and Bordujenko (1999) note that the current use of expert medical opinion in both adversarial and inquisitorial legal matters has been criticised and a number of alternatives have been suggested.⁴⁰ One alternative that they believe deserves consideration is the use of the Statements of Principles of the Repatriation Medical Authority (RMA) which state the causes, within the bounds of the Veterans' Entitlements Act, of a specified disease, injury or death on the basis of the available 'sound medical scientific evidence'. The RMA, they argue is an example of the uses of epidemiology in providing compensation-based social services. Fundamentally, they argue that this model promotes consistency and equity by the use of impartial and evidence-based decision making.

The use of SoPs will be important, for example in diagnosing PTSD and attributing its appearance to a service-related event. This will require distinguishing its (distinctive) symptoms from those of other mental illnesses. This is bearing in mind that PTSD, very frequently is suffered in concert with other accompanying mental illnesses such as anxiety, depression and substance abuse.

The SoPs will also be important in interpreting late-onset disease. Late-onset disease is frequently deemed to happen as a result of events occurring after the period of service that precipitate frank PTSD. Where previously it had not been sufficiently troublesome to require presentation to a doctor and treatment, it does now.

In this regard, the period of time before the onset is unconfined for PTSD but more time-limited for, say Anxiety Disorder. Thus, for PTSD, Category 1A and 1B stressors must be demonstrated before the clinical onset of posttraumatic stress

⁴⁰ Donald K, Bordujenko (1999) A Is it time to limit the role of the judiciary in compensation matters? Aust N Z J Public Health 23: 328-30.

disorder. For anxiety Category 1A and 1B stressors must be demonstrated within the five years before the clinical onset of Anxiety Disorder – see Endnotes of this Section for the full listing of the factors ‘that must as a minimum exist before it can be said that a reasonable hypothesis has been raised connecting the disease or death from the disease with the circumstances of a person’s relevant service’. Definitions for Category 1 A and 1B stressors are also set out there.

This means that it is much more possible to entertain the notion of a service connection for a late-onset case of PTSD than a late-onset case of Anxiety Disorder occurring, say twenty or more years after the end of a conflict. This being the case, it is usually for PTSD and not Anxiety Disorder that ‘rigorous procedures’ may be put in place to historically verify that the service-related exposure to, say a category 1A or 1B event.

This point is made because DVA has been in the practice of consulting historical military record sources to confirm whether or not there is documentary evidence of exposure to Category 1A or 1B Stressor that the veteran nominates as the relevant event responsible for their PTSD. This can be deemed to be appropriate subject to a number of caveats.

First, a degree of discretion or latitude needs to be observed in interpreting the Statement of Principle. They are statements designed to cover not only typical (mean) behaviour but the variability (variance expressed through 95% confidence intervals) around that typical behaviour. Nevertheless, they are unable to cover very unusual instances of service connections falling outside the accepted variance from typical or mean behaviour. In other words the SoPs can not be mechanistically applied.

Second, historical records are not perfect, as is frequently found when the ADF is requested to produce medical records from 20 or more years earlier.

Third, as the Pathways to care study makes clear veterans, like other members of the community with a medical condition including mental condition do not always present for treatment.⁴¹ In this study, a stratified sample of Australian veterans of different theatres of war, (World War II, Vietnam and Peacekeepers) and recently compensated for a mental health disability completed a mail questionnaire and followup telephone interview. Thirty per cent reported they were not receiving any current treatment for their mental health condition. The reasons for this were health literacy barriers, particularly in Peacekeepers, and internal barriers related to disappointment of their experience of health care and mistrust of care providers. Additionally, there were distributional issues of location and social class regarding availability and access to services.

This means that what appears to be a late-onset condition may in fact be a late-identified condition, a distinction that the US Institute of Medicine and National Research Council in their *PTSD, Compensation and Military Service* report, described in Section 7.2 above, believes is very important. It is thus possible that a claim for an Anxiety Disorder that could be deemed to be too late-onset to be accepted is in fact

⁴¹ Hawthorne G, Hayes L, Kelly C et al (2004) Pathways to care in veterans recently compensated for a mental health condition, Australian Centre for Posttraumatic Mental Health:1-261.

not late-onset but late-identified and potentially could be accepted. A detailed clinical history with supporting documentation should be able to make this clear.

Fourth, as noted by Frueh et al (2007) above, some veterans' reports of combat exposure change over time as a function of reported PTSD symptom severity. More generally, Hodson (2002) was able to demonstrate in a group of Australian Rwanda veterans that while their level of report of exposure to a traumatic event does not change greatly over time, it does change to some extent.⁴²

Potentially traumatic event	Post 4 months (n= 66) (%)	Post 6 years (n=75) (%)
In danger of being killed	75.3	87.3
In danger of being injured	92.2	94.9
Witnessed a hostage situation	27.8	35.4
Present when a friend or colleague was injured or killed	67.1	72.2
Saw dead bodies	94.9	97.5

Fifth, and most generally, the US Institute of Medicine and National Research Council in their report, make clear that while they feel confident to recommend what these rigorous assessment methods should be, they need to be further developed. They are likely to involve a suitably qualified clinician taking a structured detailed history relevant to diagnosis and possibly service connection. This would be conducted at the time of the veteran's health examination in the lead up to the submission of their claim for compensation.

Sixth, the production of documentary evidence in a tribunal or elsewhere disproving the veteran's claim is very confronting. This can be a source of considerable distress to the veteran who may believe that their honour is being challenged by the military system which they previously served and honoured. The veteran may in fact be wrong about their facts, but honestly so, either as a result of their condition or the embellishments that occur in stories told and retold over decades. As noted the historical record may also be wrong.

7.4 Tip offs and false stressor cases

In cases of suspected fraud in relation to a compensation claim for PTSD, the use of historical military record sources historical would seem a legitimate technique to investigate the veracity of a claimed exposure to a nominated traumatic stress event. They are more problematic following an anonymous 'tipoff' however, as it can not be assumed that the information provided in the tipoff is accurate. For example, a veteran with a General disability pension who is observed working is not engaged in fraudulent behaviour.

In addition it is known that many tipoffs are made by anonymous informant networks with unclear motivations. It is known that there are many animosities between individual veterans and even groups of veterans. While tipoffs need to be investigated

⁴² Hodson S (2002) Key predictors of post-trauma symptomatology in military peacekeeping veterans. Unpublished PhD thesis Macquarie University:1 -137. (adapted from Table 1 p63)

under the law, there needs to be some substantiation to ensure that the information provided is not capricious or malicious and the investigation has merit. A demonstration of fraud needs to be very clear and very obviously not open to debate, bearing in mind the six caveats noted in relation to historical record investigation set out in Section 7.3 above. A formal investigation for fraud is even more confronting to the veteran than the production of material in a tribunal hearing challenging their veracity. In the worst possible case this can manifest itself in self-harm to the veteran.

Investigations for fraud need to observe due process and be diligent in their application. Consultation with a mental health professional (psychiatrist or clinical psychologist) is essential with sign-off before contact is made with the veteran - as proposed more generally in Section 6.11.4.

7.5 Likely future trends in PTSD claims

It is useful to consider to what extent PTSD claims for post-Vietnam conflicts will mirror the Vietnam experience. As noted in Section 7.1, 17,442 (29%) of the original 60,220 Vietnam veteran cohort have received TPI pensions - 10,600 (21/6%) of 49,000 surviving Vietnam veterans. It is also known that claims as well as accepted claims for post-Vietnam conflicts are much lower. However a smaller period of time has elapsed with the post-Vietnam conflicts and it is known that the large proportion of claims for Vietnam were made many years after the end of the conflict (after the Vietnam Veterans March of 1987).

The DVA Statistics Unit has provided the following data on mental conditions accepted for compensation that is relevant to this issue. For post-Vietnam conflicts, these are based on deployments not persons and may understate proportions as a member may have more than one deployment. In addition, when a veteran has more than one accepted mental health disability all accepted disabilities are included. When a disability is attributed to service in more than one conflict it is counted under each relevant conflict. Figures therefore should not be summed. Psychoactive substance abuse has been included within 'Drug Dependence or Drug Abuse'.

The First Gulf War (early 1990s) and Rwanda Peacekeepers (1994) are the only post-Vietnam conflicts when sufficient time has elapsed to make comparison with the Vietnam experience, After 19 years, 3.0% of First Gulf War veterans and 23.9% Rwanda peacekeeper veterans compared with 2.1% of Vietnam veterans had PTSD disability claims accepted. Thus, First Gulf war veterans have similar level of claims accepted, if anything a little higher than Vietnam veterans. Almost one quarter of Rwanda veterans who observed genocide and its aftermath, were in great personal danger and had very restrictive rules of engagement have very high PTSD accepted disabilities. Their situation was exceptional and may provide little guidance for other conflicts.

It is too soon then to make any judgement about likely future number of PTSD claims. It is to be hoped that the introduction of better policies as a response to the post-Vietnam veteran experience will prevent the large number of claims made by Vietnam veterans in the period 20-9 years after the end of the conflict.

**Accepted mental disabilities attributed to service in Vietnam & subsequent conflicts
Number of years post end of conflict to acceptance - all VEA & MRCA disabilities)**

	Vietnam (n = 60,200)						
	Before Conflict End	Under 5 years	5 to 9 years	10 to 19 years	20 to 29 years	30 years or more	Total
Adjustment Disorder				9	110	46	165
Alcohol Dependence or Alcohol Abuse				61	3,007	2,123	5,191
Anxiety Disorder	454	98	186	832	1,364	384	3,318
Depressive Disorder	33	11	16	86	1,158	871	2,175
Drug Dependence or Drug Abuse				3	1,781	82	1,866
Post Traumatic Stress Disorder	10 (0.2%)	2 (0.0%)	15 (0.3%)	932 (1.6%)	12,986 (21.6%)	3,497 (5.8%)	17,442 (29.0%)
Other Conditions	84	27	73	226	203	25	638
All Mental Disorders	581	138	290	2,149	20,609	7,028	30,795

	Gulf War (Deployments = 1873)				East Timor (Deployments = 41,412)	Afghanistan*	Iraq (2003)*
	Under 5 years	5 to 9 years	10 to 19 years	Total	On Going	On Going	On Going
Adjustment Disorder		2	3	5	27	4	8
Alcohol Dependence or Alcohol Abuse		2	14	16	192	9	18
Anxiety Disorder		7	7	14	37	4	10
Depressive Disorder	2	3	13	18	191	17	42
Drug Dependence or Drug Abuse	1	1	1	3	7		1
Post Traumatic Stress Disorder	1 (0.05%)	22 (1.2%)	33 (1.8%)	56 (3.0%)	472 (1.14%)	42 (0.4%) combined	89
Other Conditions			2	2	11	1	4
All Mental Disorders	4	37	73	114	937	77	172

* Deployments to Afghanistan and Iraq combined = 30,000

	Rwanda (deployments = 618)				Other
	Under 5 years	5 to 9 years	10 to 19 years	Total	Unknown
Adjustment Disorder			1	1	14
Alcohol Dependence or Alcohol Abuse	6	15	27	48	161
Anxiety Disorder	1	2	2	5	31
Depressive Disorder	6	13	21	40	114
Drug Dependence or Drug Abuse	3	2		5	27
Post Traumatic Stress Disorder	31 (5.0%)	57 (9.2%)	60 (9.7%)	148 (23.9%)	411
Other Conditions					6
All Mental Disorders	47	89	111	247	764

7.6 Conclusion and recommendations

It is important that rigorous procedures are in place to ensure that the acceptance of a claim for compensation is justifiable and complies with the best evidence that first, a factor can be considered causal for a disease and that, second, the best information is obtained that the disease is connected to the veteran's service.

The adoption of the Statement of Principles is a major step towards the realisation of the first of these. Processes for assessing the second is less well advanced and study to identify better processes would be timely, as outlined in the report of the US Institute of Medicine and National Research Council discussed above in Section 7.2 above.

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

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

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

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

Endnote

Factors for PTSD⁴³: The factor that must as a minimum exist before it can be said that a reasonable hypothesis has been raised connecting posttraumatic stress disorder or death from posttraumatic stress disorder with the circumstances of a person's relevant service is:

- (a) experiencing a category 1A stressor before the clinical onset of posttraumatic stress disorder; or
- (b) experiencing a category 1B stressor before the clinical onset of posttraumatic stress disorder; or
- (c) having a significant other who experiences a category 1A stressor within the one year before the clinical onset of posttraumatic stress disorder; or
- (d) experiencing the traumatic death of a significant other within the two years before the clinical onset of posttraumatic stress disorder; or
- (e) experiencing a category 1A stressor before the clinical worsening of posttraumatic stress disorder; or
- (f) experiencing a category 1B stressor before the clinical worsening of posttraumatic stress disorder; or
- (g) having a significant other who experiences a category 1A stressor within the one year before the clinical worsening of posttraumatic stress disorder; or
- (h) experiencing the traumatic death of a significant other within the two years before the clinical worsening of posttraumatic stress disorder; or
- (i) inability to obtain appropriate clinical management for posttraumatic stress disorder.

Factors for anxiety disorder⁴⁴: The factor that must as a minimum exist before it can be said that a reasonable hypothesis has been raised connecting anxiety disorder or death from anxiety disorder with the circumstances of a person's relevant service is:

- (a) for generalised anxiety disorder or anxiety disorder not otherwise specified only:
 - being a prisoner of war before the clinical onset of anxiety disorder; or
 - experiencing a category 1A stressor within the five years before the clinical onset of anxiety disorder; or
 - experiencing a category 1B stressor within the five years before the clinical onset of anxiety disorder; or
 - having a significant other who experiences a category 1A stressor within the two years before the clinical onset of anxiety disorder; or
 - experiencing a category 2 stressor within the one year before the clinical onset of anxiety disorder; or
 - having a clinically significant psychiatric condition within the ten years before the clinical onset of anxiety disorder; or
 - having a medical illness or injury which is life-threatening or which results in serious physical or cognitive disability, within the five years before the clinical onset of anxiety disorder; or
 - having epilepsy at the time of the clinical onset of anxiety disorder; or
 - having chronic pain of at least three months duration at the time of the clinical onset of anxiety disorder; or
 - experiencing the death of a significant other within the two years before the clinical onset of anxiety disorder; or

⁴³ Repatriation Medical Authority (2008) Statement of Principles concerning Posttraumatic Stress Disorder No. 5 Of 2008 for the purposes of the Veterans' Entitlements Act 1986 and Military Rehabilitation and Compensation Act 2004:1-9.

⁴⁴ Repatriation Medical Authority (2007) Statement of Principles concerning Anxiety Disorder No. 101 of 2007 for the purposes of the Veterans' Entitlements Act 1986 and Military Rehabilitation and Compensation Act 2004:1-9.

- (b) for anxiety disorder due to a general medical condition only, having an endocrine, cardiovascular, respiratory, metabolic, infectious, or neurological disorder, where the general medical condition is a direct physiological cause of the anxiety at the time of the clinical onset of anxiety disorder; or
- (c) for generalised anxiety disorder or anxiety disorder not otherwise specified only:
 - (experiencing a category 1A stressor within the five years before the clinical worsening of anxiety disorder; or
 - (experiencing a category 1B stressor within the five years before the clinical worsening of anxiety disorder; or
 - having a significant other who experiences a category 1A stressor within the two years before the clinical worsening of anxiety disorder; or
 - experiencing a category 2 stressor within the one year before the clinical worsening of anxiety disorder; or
 - having a clinically significant psychiatric condition within the ten years before the clinical worsening of anxiety disorder; or
 - having a medical illness or injury which is life-threatening or which results in serious physical or cognitive disability, within the five years before the clinical worsening of anxiety disorder; or
 - having epilepsy at the time of the clinical worsening of anxiety disorder; or
 - having chronic pain of at least three months duration at the time of the clinical worsening of anxiety disorder; or
 - experiencing the death of a significant other within the two years before the clinical worsening of anxiety disorder; or
- (d) having a medical condition as specified at the time of the clinical worsening of anxiety disorder; or
- (e) inability to obtain appropriate clinical management for anxiety disorder.

A category 1A stressor means one or more of the following severe traumatic events:

- (a) experiencing a life-threatening event;
- (b) being subject to a serious physical attack or assault including rape and sexual molestation; or
- (c) being threatened with a weapon, being held captive, being kidnapped, or being tortured.

A category 1B stressor means one of the following severe traumatic events:

- (a) being an eyewitness to a person being killed or critically injured;
- (b) viewing corpses or critically injured casualties as an eyewitness;
- (c) being an eyewitness to atrocities inflicted on another person or persons;
- (d) killing or maiming a person; or
- (e) being an eyewitness to or participating in, the clearance of critically injured casualties.

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

8.1 Introduction

There are a large number of organisations representing veterans. The principal ones in relation to this study are the:

- Returned and Service League of Australia (RSL) (particularly representing veterans of World War 2);
- Vietnam Veterans Association of Australia (VVAA) (representing Vietnam Veterans);
- Vietnam Veterans Federation of Australia (VVFA) (representing Vietnam Veterans);
- Australian Peacekeeper and Peacemakers Veteran's Association (APPVA) (particularly representing younger peacekeeper and peacemakers);
- Australian Federation of Totally and Permanently Incapacitated Ex Servicemen and Women (TPI Federation) (representing DVA TPI disability pensioners);
- Partners of Veterans Association of Australia (representing partners and former partners of veterans).

A number of these bodies as well as some others are represented in the Veterans Mental Health and Wellbeing Forum.

The Ex-Service Organisations (ESOs) in Australia are very active on behalf of veterans and the ex-service community more generally. They represent and advocate for veterans particularly with Government.

The mission of the RSL, for example is

‘To ensure that programs are in place for the well-being, care, compensation and commemoration of serving and ex-service Defence Force members and their dependants; and promote Government and community awareness of the need for a secure, stable and progressive Australia.’⁴⁵

They are responsible for the delivery of a large number of services directly to veterans, for example through the RSL Foundation, RSL Legal Aid Scheme, RSL National Trusts, the RSL Welfare & Benevolent Institution and RSL accommodation services.

The ESOs have also been involved with the introduction of a number of services and benefits to veterans that are relevant to this report. These include eg the VVCS and the Training and Information Program (TIP). They take an interest in ADF Transition Services and have an opportunity to speak at Transition Seminars and mount stalls

⁴⁵ Returned and Service League of Australia RSL Mission Statement (<http://www.rsl.org.au/> - accessed 20 Jan 2009)

there so as to be able to talk to transitioning-out members out of session at the seminars.

They have been particularly involved in supporting veterans making compensation claims in relation to DVA disability pensions. They do this through their Welfare and Pension Officers who are volunteers endorsed by the ESOs. These volunteers are eligible for the Veterans' Indemnity and Training Association (VITA) professional indemnity insurance after suitable training, qualification and authorisation.⁴⁶

Younger veterans with lesser involvement with ESOs often use lawyers particularly for MRCA or SRCA applications.

8.2 TIP and BEST programs

Welfare and Pension Officers have a number of roles. As Pension officers, they are expected to provide advice under all three veterans compensation acts. As Welfare officers, they are expected to provide information on all DVA's health, housing and others services available for veterans, their dependants, war widows and former serving members as well as on community services more generally.

In their roles as ESO Pension officers supporting veterans making compensation claims, they may also act as Advocates at appeal hearings to the Veterans' Pensions Officers, refresher and update training and advanced training for Review Board and the Administrative Appeals Tribunal.

The Training and Information Program (TIP) provides training and information for Welfare and Pensions Officers. TIP is a joint venture between ESOs and the Department of Veterans' Affairs (DVA) and offers training for new Welfare and experienced Welfare and Pensions Officers.

The Building Excellence in Support and Training (BEST) Program is the companion program to TIP.⁴⁷ BEST funding can provide assistance for salary costs for full or part time practitioners by ESOs, salary costs for full or part time administrative support staff, computer equipment used to assist ESO practitioners and consumables, running costs and other general costs relating to the lodgement of claims and appeals.

Currently then, some Officers are paid but most are unpaid volunteers. On occasions where there is a shortage of volunteer Officers, DVA may provide additional funding to overcome the effects of this shortage.

8.3 Support for veterans making compensation in other countries

Canada: The best known scheme providing support for veterans making compensation claims in other counties is the Canadian Bureau of Pensions Advocates.

⁴⁶ Department of Veterans Affairs Training & Information Program (TIP)
(http://www.dva.gov.au/grants_best_tip/tip/index.htm#Insurancecover - accessed 20 Jan 2009)

⁴⁷ Department of Veterans Affairs Building Excellence in Support and Training (BEST)
(<http://www.dva.gov.au/pensions/BEST&TIP/B&Tindex.htm> - accessed at 20 Jan 2009)

As stated on their website, the Bureau of Pensions Advocates (BPA) is a nation-wide organization of lawyers within Veterans Affairs Canada.⁴⁸ It provides free legal help for people who are not satisfied with decisions about their claims for disability benefits. BPA represents between 90% - 95% of all claims that proceed to the Veterans Review and Appeals Board (VRAB), which is an independent, tribunal that makes decisions on reviews and appeals of disability pensions and final appeals on war Veterans allowances. Its staff investigate the veteran's condition to determine if supportive evidence is needed, such as medical reports or documentation by consultants. The BPA support Departmental Reviews, Review Hearings, Appeal Hearings and Judicial Reviews.

The Royal Canadian Legion have Royal Veteran Services Service Officers who help at all levels of the governmental process, including the Veterans Review and Appeal Board.⁴⁹

UK: As stated on the Ministry of Defence's website, the Armed Forces Compensation Scheme has been recently introduced and replaced an earlier scheme – see Section 6.10.⁵⁰ It provides lump sum award (in four bands) for pain and suffering for significant qualifying injuries and illnesses.⁵¹ Larger payments will go to the more seriously disabled. It takes into account the expected level of deterioration. It also offers a tax-free Guaranteed Income Payment (GIP) for life for those at the higher levels of the tariff (1-11) to compensate for loss of earnings capacity. The value of the income payment is set at different levels, dependent on the expected degree of lost earnings capacity caused by the disablement.

It is run by Service Personnel & Veterans Agency (SPVA) also known as Veterans-UK. The Royal British Legion, the largest organisation representing veterans in the UK as well as other ESOs represent veterans at Pensions Appeal Tribunals.⁵² They each support advocates adopting a Code of Practice for Appellant's Representative at Pensions Appeal Tribunals. Advocates should have received formal training, approved by the respective charity, upon several aspects of representation such as the applicable law and procedure, the principles of advocacy and dealing with the preparation of the appeal from the outset and consideration of evidence.

In the US, veterans and other claimants for VA benefits have the right to appeal decisions made by a VA regional office.⁵³ The veteran can appeal a complete or

⁴⁸ Bureau of Pensions Advocates BPA Responsibilities and Initiatives (<http://www.vac-acc.gc.ca/clients/sub.cfm?source=department/organization/respons> - accessed 20 Jan 2009)

⁴⁹ The Royal Canadian Legion Veteran Services. Service Officers help at a community level and at all levels of the governmental process, including the Veterans Review and Appeal Board (VRAB) (http://www.legion.ca/About/veteran_e.cfm - accessed 20 Jan 2009)

⁵⁰ Ministry of Defence UK Key features of the Armed Forces Compensation Scheme (AFCS) (<http://www.mod.uk/DefenceInternet/AboutDefence/WhatWeDo/Personnel/Pensions/ArmedForcesPensions/AFCS/KeyFeaturesOfTheArmedForcesCompensationSchemeafcs.htm> - accessed 16 Jan 2009).

⁵¹ Veterans UK Pensions Compensation Armed Forces Compensation Scheme (AFCS) 3

⁵² Confederation of British Service and Ex-service Organisations (COBSEO) Guidelines – No 1 of 2008 The Appellant's Representative at Pensions Appeal Tribunals - Code of Practice (http://www.britishlegion.org.uk/uploads/documents/COBSEO_CodeofPractise.pdf - accessed 20 Jan 2009)

⁵³ Military.com Benefits The Appeals Process Overview (<http://www.military.com/benefits/legal-matters/appeals-process/appeals-process-overview> - accessed 20 Jan 2009)

partial denial of your claim or the level of benefit granted. Appeals are made to the Board of Veterans' Appeals and the U.S. Court of Appeals for Veterans Claims. The American Legion Veterans have Department Service Officers (DSO) who offer free advice and guidance for veterans who need to deal with the Department of Veterans Affairs (VA).⁵⁴

8.4 Assessment

This overall assessment is based on a review of all technical and research documents, stakeholder input, review of records of veterans who had committed suicide, nominated by the Veterans Mental Health and Wellbeing Forum and public submissions. A summary of themes arising out of both individuals and organisation submissions relevant to *Mental health, compensation & the Ex-Service Organisations* are included in Appendix 1.

The ESOs have clearly 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 an important contribution in providing training, some salary and other support to Officers.

Some problems have emerged though. The large majority of volunteers who have become Officers are themselves veterans of conflicts that are no longer recent (Second World War and Vietnam conflict). They largely are members of the ESOs servicing these conflicts - RSL, VVAA and VVFA - and they receive their endorsement as Officers from these organisations. These constitute therefore an ageing (mostly unpaid) workforce

However membership in ESOs from where the volunteers are largely drawn is much less common in younger veterans who have participated in the post-Vietnam conflicts and peacekeeping activities.⁵⁵ They are a new generation with new interests and opportunities. Volunteerism by its nature means that volunteers are active for a period, become less active and need to be replaced from a pool of other volunteers. But these younger volunteers are fewer and volunteers will become fewer as a result.

As they grow older, their age difference with younger veterans also increases. This may detract at least some younger veterans from taking advantages of their services. 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. As discussed in Section 6.11.2, understanding the three compensation schemes and the other disability-related income support schemes is very complex not only for Officers and indeed all involved.

⁵⁴ The American legion DSO – Department Services officers Directory
(<http://www.militabenefits/legal-mattes/appeals-process-overview> - accessed 20 Jan 2009)

⁵⁵ This may change in the future with the active efforts of the Australian Peacekeeper and Peacemakers Veteran's Association (APPVA) to recruit younger veterans.

Appearing as an advocate at VRB and AAT hearings requires aptitude and skill and is a large responsibility. The advocate may feel very responsible if the appeal is unsuccessful. Advocates may make mistakes (or feel they have done so) with unfortunate consequences for the veteran making the appeal.

Training by its nature produces more effective Officers. Experience by its nature produces Officers more able to cope with lack of success at an appeal hearing.

There are currently no accreditation standards for being a Welfare and Pension Officer. TIP training is not assessed and it may be felt that assessment may adversely affect recruitment numbers for these volunteers.

8.4.1 Need for a new system

It is now time, having recognised again the contribution of the volunteer officers to move to a new system. Veterans should have available to them the best advice available from government, from ESOs or both. This again will be recognising that it will be difficult for them to navigate a complex veteran compensation system and other disability-related income support schemes.

Usually this support has involved an ESO. Veterans may feel that when government public servants (the DVA delegate in the Australia) provide advice that it is not solely as their agents. They may feel that the delegates have to balance an agency for the veteran with that of their department which represents the government and public interest.

This is not to argue of course that the provision of best advice from government is unimportant. It is interesting too that the Canadian Bureau of Pension Advocates, while part of Veterans Affairs Canada provides advice solely to the veteran in appeal situations as their agent.

In designing a new system in the Australian context, it will be more appropriate that:

- ESOs will be involved;
- Officers will need to operate increasingly on a paid basis;
- That training may need to be to a higher standard appropriate to a TAFE Certificate 4 or Diploma qualification;
- DVA will be involved in funding the new system; and
- the new system will need to take into account that younger veterans are becoming members of ESOs to a much lesser extent than previously;
- a form of quality assurance is required to provide added confidence that the system was working well.

Issues surrounding funding and training are not inconsiderable. It may be more difficult however to devise system that desirably involves the ESOs but recognises that younger veterans are less oriented to the ESOs than previously.

One option would be to train Officers who are endorsed by an ESO and who would then operate very closely with the ESO and leave veterans who do not wish to use their services to retain private lawyers that they pay themselves. Another option would be support two groups of Officers one operating closely with ESOs and the

other operating independently (with or without external support for their professional indemnity insurance). A third option would be for all Officers to remain endorsed by ESO but to operate more independently in relation to the ESO. Thus, while they might operate out of the ESO's building at some time during the week, they might operate in separate offices or on a mobile basis, visiting veterans in their home.

If accreditation was introduced, it would raise the question what would happen to the volunteer Pension Officers currently operating in the system and making an important contribution. It may be possible however to define a level or type of assistance that does not require the extra qualification and the accreditation it brings. For example, volunteers could assess and triage all cases and retain only straightforward cases involving primary VEA claims. Or alternatively the accredited officers could triage and refer on the straightforward cases to unaccredited volunteers, retaining the more difficult for themselves.

Whatever system change was supported the work for Pension Officers would reduce if Recommendation 3.5 was supported (return of an incomplete veteran's claim for further workup).

8.5 Recommendations

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

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

Both groups would be subject to appropriate quality assurance procedures.

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

Section 9 Mental health programs and services for veterans

9.1 Repatriation and other health services and programs

DVA offer a variety of medical, hospital, pharmaceutical and allied health services to veterans. These vary somewhat depending upon entitlement. Medical services are supported by two main Repatriation health cards. These are the:

- *Gold Card Repatriation Health Card - for all conditions* enables the holder to access health care and related services for all health care needs, for all conditions, whether they are related to war service or not.
- *White Card Repatriation Health Card - for specific conditions* enables the holder to access health care and associated services for specific conditions. Holders are eligible to receive, for these conditions, treatment from nominated medical, hospital, pharmaceutical, dental and allied health care providers as well as travel assistance. These specific conditions whether deployment-related or not include PTSD and - for Vietnam veterans only - anxiety and depression.

Hospital care for eligible veterans and war widows/widowers is provided through the Repatriation Private Patient Scheme (RPPS). This allows them to be admitted directly to a public hospital, former Repatriation General Hospital or contracted private Tier 1 hospital as a private patient, in a shared ward, with the doctor of his or her choice.⁵⁶ In addition, the Repatriation Comprehensive Care Scheme (RCCS) offers care to ageing veterans through GPs as DVA Local Medical Officers (LMOs) acting as care coordinators.⁵⁷

Repatriation health cards are issued by the DVA to veterans and dependants who are eligible under either the *Veterans' Entitlements Act 1986* or the *Military Rehabilitation and Compensation Act 2004* for treatment at the Department's expense. These cards are issued by Medicare Australia on behalf of DVA for medical, hospital and allied health services for veterans and other eligible individuals.⁵⁸

DVA-supported health services and programs are provided to veterans with mental illnesses.⁵⁹ In addition DVA offers a number of more specialised programs and services relating to mental health and mental illness. These programs and services range from mental health and literacy promotion, professional development programs for mental health providers and veteran counselling services including for the family of veterans. It offers specialised services to veterans with longstanding mental illness.

⁵⁶ Department of Veterans' Affairs Hospitals Index Page
(<http://www.dva.gov.au/health/hospital/index.htm>- accessed Jan 23 2009).

⁵⁷ Department of Veterans' Affairs Repatriation Comprehensive Care Scheme
(<http://www.dva.gov.au/health/provider/rccs/rces.htm> - accessed Jan 23 2009).

⁵⁸ Medicare Australia Mediguide Section 8 Veterans' Affairs processing
(http://www.medicareaustralia.gov.au/provider/pubs/mediguide/files/mediguide_2007_section_8.pdf - accessed Jan 23 2009)

⁵⁹ Veterans still serving in the ADF receive health services from Defence Health. There is also an ADF Mental Health Strategy which promotes mental health and mental health literacy.

It is further developing programs to encourage veterans, not currently using these services, and who would gain benefit to do so.

The latter rather than the former group of programs and services is most relevant to the Terms of Reference of this Study and will form the principal focus of this Section.

9.2 Specialised mental health programs and services for veterans

9.2.1 Mental health promotion and literacy programs

At Ease

The At Ease website targets veterans, their families including current serving ADF members.⁶⁰ It enables the user to:

- understand and self-manage common mental health conditions from a veteran's perspective;
- access services and online resources that are available to help veterans cope with mental illness;
- DVA mental health news and event information.

Services include various treatment options eg GPs (LMOs) (including for mental health assessments), Allied Health Professionals, medical specialists and VVCS. The website also contains resources for health professionals.

The Right Mix

The Right Mix aims to create opportunities to reduce alcohol-related harm in the veteran community and ensure that alcohol and related problems are addressed in an integrated way with other physical and mental health conditions and encompass prevention, early intervention, treatment and relapse prevention.⁶¹ The Right Mix website features an interactive self-assessment tool by which veterans can assess their drinking behaviour. It also provides access to all the health promotion materials and information on where veterans and their families can seek help. The website again also contains resources for health professionals.

The Right Mix has been evaluated by ACPMH on contract with DVA.

Operation Life

Operation *Life* is concerned with suicide prevention and broader issues and was discussed further in Section 2 above.

⁶⁰ Department of Veterans' Affairs At Ease (<http://at-ease.dva.gov.au/www/html/7-home-page.asp> - accessed 23 Jan 2009).

⁶¹ The Australian Government Mental health & well being What is The Right Mix – Your Health and Alcohol? (<http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/right-mix-2> - accessed 23 Jan 2009).

National Veterans Mental Health and Wellbeing Forum

The National Veterans Mental Health and Wellbeing Forum is the principal forum for the veteran community to provide advice the Minister on mental health issues.⁶² In turn, forum members educate and inform the veteran community about what DVA activity in mental health. Its main aims are to:

1. provide a sounding board for advice on Government mental health programs, services and initiatives, particularly as they affect the veteran community;
2. respond to requests for advice on specific matters referred to the Forum by the Minister;
3. initiate reviews or investigations on matters agreed with the Minister;
4. encourage approaches between ex-service organisations, health providers, DoD and DVA that support the adoption of recovery and wellbeing orientations to mental health issues. This should focus on prevention, early intervention, diagnosis, assessment, rehabilitation, treatment and relapse management;
5. assist in the development of educative processes to disseminate accurate and consistent information to veterans, their families and carers about the range of mental health issues experienced in the veteran community and how to identify and access effective mental health services and programs.

Members of the Forum are appointed by the Minister for Veterans' Affairs as representatives of the principal ESOs. It is chaired by the National President of the RSL.

9.2.2 Education of health professionals

Can Do

'Can Do' Initiative: Managing Mental Health and Substance Use in General Practice is a national Initiative, funded through the Australian Government Department of Health and Ageing as part of the National Comorbidity Initiative.⁶³ It is delivered at local level through Divisions of General Practice.

The initiative promotes a 'Can Do' approach to general practice to meet the challenge of mental health and substance use and focuses on education, training and networking between two multidisciplinary teams of health professionals:

- general practice teams; and
- community health teams (especially those engaged in alcohol and drug service, community pharmacy and mental health service delivery).

'Can Do' now comprises several components including Teams of Two, Clinical Education and eight population specific modules. The Training Package consists of a network and a clinical education module.⁶⁴ The network module involves joint

⁶² Department of Veterans' Affairs National Veterans Mental Health and Wellbeing Forum (<http://www.dva.gov.au/health/younger/mhealth/nvmhmf.htm> - accessed 23 Jan 2009).

⁶³ Australian General Practice Network 'Can Do' Initiative: Managing Mental Health and Substance Use in General Practice (<http://www.agpncando.com/pdf> - accessed 23 Jan 2009).

⁶⁴ Australian General Practice Network Managing Mental Health and Substance Use in General Practice ANEX Conference - September 2007

learning; peer discussion; case discussion (and story telling); mapping local resources; identifying referral pathways; and compilation of key services, contacts and local information. The clinical education module involves clinical presentations; multidisciplinary training; case studies; and care planning.

The eight population specific modules include 'Can Do' for Veterans but also 'Can Do' for Young People, Families and Carers, Indigenous People (in rural and remote communities), Men in Rural Areas, Young Women with Children, CALD People and the Elderly. 'Can Do' for Veterans operates in 17 (of 111) Divisions of General Practice in which large numbers of veterans are known to live. This program is also aimed at increasing GP's awareness of veterans' issues, knowledge of PTSD and other conditions and also increasing their awareness of other resource for GPs such as appropriate referral pathways to VVCS, the veteran units at key hospitals and other relevant services.

It will be evaluated by ACPMH as part of it's work on contract with DVA to evaluate it's Mental Health Initiatives for 2007-10.⁶⁵

Mental Health Advice Book for practitioners helping veterans with common mental health problems

This is one of the resources for health professionals on the At Ease website noted above.⁶⁶ It was developed by ACPMH, on contract with DVA. The first section outlines the background to the veteran community and their common mental health problems - understanding the veteran experience and assessment of mental health problems. The second section outlines screening, assessment and treatment of the common mental health problems of veterans. These include eg depression and dysthymia, anxiety disorders, somatoform and substance use disorders.

Australian Government Training for Mental Health Workers Initiative

This initiative is aimed at secondary care providers, in contrast to the Mental Health Advice Book which is aimed at primary care providers. It is being conducted by ACPMH, on contract with DVA during 2008-11.⁶⁷ It aims to enhance the competency of community-based mental health practitioners to provide veterans with evidence-based best practice interventions for common mental health problems. It involves a national training program to provide practitioners with practical tools to deal with complex cases. Competencies are training priorities are currently being defined. Training workshops will take place in regional centres in every state. Practitioners will be assigned to a network of colleagues in their local area, to share information and provide peer support and advice. Practitioners will also receive ongoing follow-up support and expert consultation.

(http://www.anex.org.au/conference/downloads/speakers/Schultz_Meriel.pdf - accessed 23 Jan 2009)

⁶⁵ Australian Centre for Posttraumatic Mental Health (2008) Evaluation of Department of Veterans' Affairs Mental Health Initiatives 2007-10 Progress Report. Australian Centre for Posttraumatic Mental Health, Melbourne: 1-100.

⁶⁶ Department of Veterans' Affairs At Ease Mental Health Advice Book for practitioners helping veterans with common mental health problems

(<http://at-ease.dva.gov.au/www/html/251-contents.asp> - accessed 23 Jan 2009).

⁶⁷ Australian Centre for Posttraumatic Mental Health Training for mental health practitioner's initiative (<http://www.acpmh.unimelb.edu.au/services/traininginitiative.html> - accessed 23 Jan 2009)

9.2.3 Counselling services

Veterans and Veterans Families Counselling Service (VVCS)

VVCS provides counselling and group programs to Australian veterans/peacekeepers and their families as well as former ADF members with a DVA disability pension for a mental condition.⁶⁸ VVCS staff are psychologists or social workers with experience in working with veterans, peacekeepers and their families. They provide a range of programs and treatments for war and service-related mental health conditions including post traumatic stress disorder (PTSD). It is a free and confidential service.

It offers individual, couple and family counselling for issues such as stress, relationship and family problems, alcohol and other drugs and psychological or emotional difficulties. It has an Outreach Program for veterans living in rural, remote and outer metropolitan areas. It also offers group Programs and make referrals to specialist services and treatment programs such as psychiatric assessments for partners and children of Vietnam veterans, PTSD programs and treatment facilities and specialised clinical services eg alcohol treatment programs. It also operates Veterans Line (see below).

VVCS is part of DVA. It is supported by veterans, particularly Vietnam Veterans as its previous name, Vietnam Veterans Counselling Service indicated. It operates outside the ADF but has a close relationship with the ADF, as can be seen below.

As a result of the heightened operational tempo of the ADF in recent years, many veterans are still members of the ADF and are therefore eligible for counselling from the VVCS. Other current ADF members are referred by the ADF to VVCS.

Some major ADF bases around Australia, to a varying extent contract VVCS to do counselling work on its behalf. For example, in Townsville, VVCS operates out of the Lavarack Medical Centre as well as its own office. Its caseload in Townsville of 1600 in 2007 included 650-700 ADF members and their families. It has seven counsellors on staff with 24 others on contract though no doctors or psychiatrists. VVCS is able to provide services without significant waiting time in contrast to the two PSSs in Townsville (Lavarack Barracks, which has a 3-4 week waiting list and elsewhere in Townsville).

VVCS as an organisation has recently signed a Memorandum of Understanding (MoU) with the ADF establishing clear policies and practices. Specifically this involves VVCS sending a clinical report back to the ADF for insertion in the member's medical records, following a referral from the Medical Officer, as case manager to VVCS. This will not be done for self-referrals, though a numerical count of these cases and the nature of their problems will be maintained and sent to the ADF periodically.

⁶⁸ VVCS - Veterans and Veterans Families Counselling Service (<http://www.dva.gov.au/health/vvcs/vvcs.htm#vvcs> – accessed 23 Jan 2009).

Veterans Line

Veterans Line is the after hours crisis counselling service provided by the VVCS.⁶⁹ Veterans Line counselling is provided by counsellors by Crisis Support Services on contract with VVCS. Counselling staff receive formal training in crisis counselling as well as specialised training in veteran's issues.

Veterans Line counsellors can assist clients who are angry, upset, anxious, depressed or have other difficulties such as relationship issues with friends and family members, grief and loss, anxiety and depression, psychological or emotional concerns and other stressful situations. Veterans Line can also organise follow up by VVCS the next business day and offer direct assistance for callers who are in crisis, or provide appropriate referrals to health professionals and community services throughout Australia. Many callers choose to remain anonymous when talking to Veterans Line and the service respects that choice.

9.2.4 Lifecycle project targeting 'hard to engage' ex-service members

One project of the Lifecycle package for ADF and veteran's mental health is the trial to Engage More Former Serving Members in Mental Health Care. It is aimed at veterans with mental health problems who do not access treatment or are not effectively engaged in mental health care.⁷⁰ They may or may not have an accepted mental health disability. While some of the barriers to veterans' access to care are known following the Pathway to care study, others are not.⁷¹ This initiative seeks to understand how veterans with mental health problems can be more effectively engaged in mental health care and to trial some practical solutions.

Hard to engage clients have been identified as: veterans with an undisclosed mental health problem; former serving members with an accepted mental health disability who do not access treatment; former serving members who attend treatment erratically or in crisis; former serving members with poor access to mental health services or whose needs are not met by existing services; former serving members living on the fringes of society eg homeless, itinerant, remote locations who may or may not have contact with DVA; former serving members for whom an acrimonious relationship with DVA appears to interfere with their readiness to engage in treatment.⁷²

Potential interventions considered include: improved detection and early intervention; improved treatment in primary care; integration of mental health into primary care;

⁶⁹ VVCS – Veterans and Veterans Families Counselling Service. Veterans Line VVCS FACTS VCS10 (<http://www.dva.gov.au/factsheets/default.htm> - accessed 23 Jan 2009).

⁷⁰ Australian Centre for Posttraumatic Mental Health Lifecycle initiatives (<http://www.acpmh.unimelb.edu.au/services/lifecycle.html> - accessed 23 Jan 2009)

⁷¹ Hawthorne G, Hayes L, Kelly C et al (2004) Pathways to care in veterans recently compensated for a mental health condition, Australian Centre for Posttraumatic Mental Health: 1-261.

⁷² Australian Centre for Posttraumatic Mental Health (2008) The Australian Government Lifecycle Package Improving treatment options for 'hard to engage' clients. Report for the Lifecycle Reference Group: 1-99.

outreach models; motivational interviewing and enhancement; telephone monitoring and support; and web-based service models.

9.2.5 Specialised PTSD clinics

There are programs funded by the DVA in every state and territory, except NT and are accredited by ACPMH⁷³ ⁷⁴ They provide specialised treatment for veterans and ADF members with PTSD and related mental health conditions. The clinics provide inpatient/outpatient/ models, day hospital programs and less intensive community based treatments. Two clinics at Mater Misericordiae Hospital Townsville and the Veterans Psychiatry Unit PTSD Program at the Austin and Repatriation Medical Centre (ARMC), Melbourne are described to illustrate the types of services provided.

The Mater Hospital offers an 8-week day-hospital PTSD-treatment program conducted on an outpatient basis. The program consists an Entry phase (2 weeks of 2 days-per-week) followed by an Intensive phase (4 weeks of 4 days-per-week) then an Exit phase (2 weeks of 2-days-per-week).

The Veterans Psychiatry Unit PTSD program involves a mixture of individual and group therapy, typically extending over 12 weeks. Four formats of treatment are currently offered:

- Intensive (inpatient or residential) Program (4-week intensive phase and 8-week outpatient phase):
- Young Veterans Program - similar to the Intensive Program but content tailored for younger veterans;
- Day Hospital Program;
- Country-located Program – similar to the Day Hospital Treatment Model;
- Evening Outpatient Program

9.3 DVA mental health policy

A number of the programs described in Section 9.2 above arose out of DVA's Mental Health Policy and Strategic Directions paper '*Towards Better Mental Health for the Veteran Community* of 2001 – see Section 9.2.1.⁷⁵ Four strategic directions with key objectives to guide mental health care for veterans were described in this paper. These are set out over.

The Repatriation Commission in 2004 proposed reforms to mental health care services for veterans in a consultation paper *Improving access to community based mental health care options for veterans*.⁷⁶ Its proposed reforms covered both areas

⁷³ Australian Centre for Posttraumatic Mental Health PTSD treatment programs for veterans and serving personnel (http://www.acpmh.unimelb.edu.au/trauma/ptsd_programs.html - accessed 24 Jan 2009)

⁷⁴ These are part of the Repatriation Medical System but, because of their relevance are described here.

⁷⁵ Department of Veterans' Affairs Mental Health Policy and Strategic Directions paper '*Towards Better Mental Health for the Veteran Community* (<http://www.dva.gov.au/health/younger/mhealth/policy/pdfs/mhpolicy.pdf> - accessed 24 Jan 2009)

⁷⁶ *Improving access to community based mental health care options for veterans*. Consultation Paper (<http://www.dva.gov.au/health/younger/mhealth/policy/consultpaper.htm>) – accessed 24 Jan 2009)

relevant to this Study and reforms more generally within the Repatriation Medical System. The ones relevant to this Study are set out below:

- Promote the use of evidence based assessment and treatment practice guidelines as recommended by the Australian Centre for Posttraumatic Mental Health (ACPMH) and relevant medical colleges;
- Extend the range of community based mental health treatment options available to veterans. Priority will be given to guidelines for community based treatment of posttraumatic mental health conditions, alcohol and substance misuse, depression and anxiety disorders;
- Through the ACPMH and other bodies develop relevant mental health education and training information that will be made available to specialist and primary care providers to enhance their knowledge and skills in meeting the mental health needs of veterans and their families.

STRATEGIC DIRECTIONS	KEY OBJECTIVES
Enabling a comprehensive approach to mental health care	<ul style="list-style-type: none"> • Improve the balance and integration of mental health care • Strengthen the mental health role of primary health care • Improve access to care before and following compensation
Responding to specific mental health needs	<ul style="list-style-type: none"> • Broaden the mental health focus beyond PTSD • Respond to alcohol and substance use disorders and related problems • Meet the mental health needs of the ageing population • Improve services for rural veterans
Planning and purchasing effective services	<ul style="list-style-type: none"> • Build a national planning framework • Move from funder to purchaser of mental health care • Improve service quality and outcomes • Support policy and program development with quality management information
Strengthening partnerships and participation in mental health care	<ul style="list-style-type: none"> • Strengthen participation in decision making about mental health care • Work with Defence on mental health promotion and prevention strategies • To be an active participant in the National Mental Health Strategy

ACPMH, on contract with DVA is conducting an evaluation of DVA's Mental Health Initiatives for 2007-10.⁷⁷

9.4 DVA-supported research

DVA has provided ongoing funding for two large research centres (alongside the ADF) as well as several very large research programs and projects. More recently it has been involved in funding of several projects within The Australian Government Lifecycle package for ADF and veteran's mental health. These centres as well as the principal programs and projects are set out below.

⁷⁷ Australian Centre for Posttraumatic Mental Health (2008) Evaluation of Department of Veterans' Affairs Mental Health Initiatives 2007-10 Progress Report. Australian Centre for Posttraumatic Mental Health, Melbourne:1-100.

Australian Centre for Posttraumatic Mental Health (ACPMH)

As stated on their website, the ACPMH which is affiliated with The University of Melbourne undertakes trauma-related research, policy advice, service development and education.⁷⁸ It receives funding from both the DVA and DoD. Its work assists organisations and health professionals who work with people affected by traumatic events. It produces an annual literature summary of articles in the field of PTSD and related conditions.⁷⁹ It has also overseen the development of the Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder.⁸⁰ Its Pathways to care study was very significant.⁸¹ It studied veterans compensated for a mental health disability over the previous eight years. A major finding was that about third of these veterans were not receiving treatment for their mental health condition.

The Centre for Military and Veterans' Health (CMVH)

As stated on their website, the Centre for Military and Veterans' Health (CMVH) is a multidisciplinary centre, focusing specifically on the health of ADF members during and after their service. CMVH is a consortium led by The University of Queensland, with The University of Adelaide and Charles Darwin University, and supported by the DoD and the DVA.⁸²

It is conducting the Deployment Health Surveillance Program (DHSP). These are cross-sectional studies of serving and ex-serving personnel who have deployed on specific operations and which aim to develop a longitudinal health surveillance system for personnel who have served in the military. Each looks at the effect of specific deployments on the health of ADF members. Currently the program is studying deployments to the Solomon Islands, Bougainville, East Timor and the Middle East Area of Operations. Data sources include defence health and exposure data, self-reported data (questionnaires); National Death Index; State and Territory cancer registries.^{83 84}

CMVH has developed a research protocol concerning the Intergenerational Health Effects of Service in the Military on Vietnam veterans.⁸⁵

⁷⁸ Australian Centre for Posttraumatic Mental Health (<http://www.acpmh.unimelb.edu.au/> accessed Jan 5 2009)

⁷⁹ Annual Literature Summary (http://www.acpmh.unimelb.edu.au/resources/lit_summary.html accessed Jan 1 2009)

⁸⁰ (<http://www.acpmh.unimelb.edu.au/trauma/ptsd.html> accessed Jan 1 2009)

⁸¹ Hawthorne G, Hayes L, Kelly C et al (2004) Pathways to care in veterans recently compensated for a mental health condition, Australian Centre for Posttraumatic Mental Health:1-261.

⁸² The Centre for Military and Veterans' Health (<http://www.uq.edu.au/cmvh/http://www.uq.edu.au/cmvh/> accessed Jan 3 2009)

⁸³ Deployment Health Surveillance Program (<http://www.uq.edu.au/cmvh/dhsp> accessed Jan 3 2009)

⁸⁴ Treloar S, McFarlane A, Ellis N (2007) Initiating an Australian Deployment Health Surveillance Program. *J Mil Vet Health* 16: 6-7.

⁸⁵ Intergenerational Health Effects of Service in the Military (<http://www.uq.edu.au/cmvh/intergenerational-health-effects-of-service-in-the-military-research-protocol> accessed Jan 3 2009)

The Australian Government Lifecycle package for ADF and veterans mental health

The Australian Government has launched a Lifecycle package for ADF and veterans mental health (pilot trials with linked research and evaluation). These are being conducted in conjunction with the Australian Centre for Posttraumatic Mental Health (ACPMH) on contract with the ADF or DVA, and consist as set out below (lead agency(ies) in brackets):

Stage 1 Entry to the ADF

- 1 A study of psychological resilience in ADF recruits (ADF)
- 2 Pilot study of resilience-building initiatives (in conjunction with the Directorate of Mental Health (ADF))

Stage 2 During ADF service

- 3 Routine annual mental health checks (ADF)

Stage 3 Transition out of the ADF - see Section 5.6

- 4 Family support trial (Townsville) (ADF/DVA)
- 5 Transition case management pilot (Townsville) (ADF/DVA)

Stage 4 Rehabilitation into civilian life

- 6 Study into the barriers to veterans' social and occupational rehabilitation (DVA) – see Sections 6.10.
- 7 Education campaign on social and occupational rehabilitation (ADF/DVA)
- 8 Study into improving treatment use by 'hard to engage' ex-service members (DVA) – see Sections 9.2.4.
- 9 Self-care trial for hard to reach ex-service members. (DVA)

Health and mortality studies of war veterans relevant to mental health

The health studies relevant to mental health include:

- Health Study 2005: Australian Veterans of the Korean War ⁸⁶
- The Australian Vietnam Veterans Health Study⁸⁷
- Morbidity of Vietnam veterans: A study of the health of Australia's Vietnam veteran community⁸⁸
- Australian Gulf War Veterans' Health Study⁸⁹

The mortality studies relevant to mental health include:

- Mortality of Korean War veterans⁹⁰
- Mortality of Vietnam veterans: the veteran cohort study. (this also includes the study of mortality of National Service Vietnam Veterans)⁹¹

⁸⁶ Sim M, Ikin J, McKenzie D: 2005. Health Study of Australian Veterans of the Korean War. In. Department of Epidemiology and Preventive Medicine, Monash University; Clayton.

⁸⁷ O'Toole BI, Marshall RP, Grayson DA et al. (1996) The Australian Vietnam Veterans Health Study: II. self-reported health of veterans compared with the Australian population. *International journal of epidemiology*, 25(2):319-330.

⁸⁸ See eg Australian Institute of Health and Welfare. Morbidity of Vietnam veterans: A study of the health of Australia's Vietnam veteran community: Volume 3 validation study. Canberra: AIHW.

⁸⁹ Occupational and Environmental Health Unit: Monash University (2003) Australian Gulf War Veterans' Health Study. Department of Veterans' Affairs, Canberra.

⁹⁰ Harrex WK, Horsley KW, Jelfs P, van der Hoek R, Wilson EJ. Mortality of Korean War veterans: the veteran cohort study. A report of the 2002 retrospective cohort study of Australian veterans of the Korean War. Canberra: Department of Veterans' Affairs, 2003.

- The Third Australian Vietnam Veterans Mortality Study 2005.⁹²
(http://www.dva.gov.au/media/publicat/2006/vietnam_health_studies/vvms/index.htm accessed Jan 3 2009).

Veterans and War Widows - Your Lives, Your Needs

In 2006, DVA commissioned the Nielsen Company to carry out the fifth in a series of surveys of Repatriation Health Card holders (as well as SRCA clients and their carers for the first time).⁹³ Its aim was to identify the needs of the veteran community and develop ways for DVA to better meet those needs. In particular, the survey aimed to measure the health of veterans, their level of independence, the effect of existing programs on veteran health and lifestyle. It also aimed to identify the service and support needs of veterans and in what ways DVA could assist in meeting these needs..

2007 National Survey of Mental Health and Wellbeing

The 2007 National Survey of Mental Health and Wellbeing reported levels for ADF members (combined with ex-service members and individuals with overseas qualifying services) who met criteria for at least one mental condition in the past 12 months compared to the rest of the Australian population.⁹⁴

Australia's health 2008 - Australian Institute of Health and Welfare

Suicide rates along with other causes of mortality for fulltime ADF members were compared with other general members of the Australian population after adjusting for their different age and sex structures.⁹⁵ The Standardised Mortality Rate (SMR) for full-time ADF members in 2001/2 – 2006/7 was 0.54 for all cause mortality (indicating prevalence levels almost half of community rates) and 0.60 for suicide (indicating prevalence levels 60% of community rates).

DVA's clinical database

DVA maintain a clinical database using TRIM Systems software. It records occasions of service (though not diagnosis), medicines prescribed under the RPBS on the occasion, plus any linked results from veterans' research studies and surveys.

⁹¹ Crane PJ, Barnard DL, Horsley KD, Adena MA. Mortality of Vietnam veterans: the veteran cohort study. A report of the 1996 retrospective cohort study of Australian Vietnam Veterans. Department of Veterans' Affairs, Canberra:, 1997.

⁹² The Third Australian Vietnam Veterans Mortality Study 2005.
(http://www.dva.gov.au/media/publicat/2006/vietnam_health_studies/vvms/index.htm accessed Jan 3 2009).

⁹³ Department of Veterans' Affairs Australian Veterans and War Widows - Your Lives, Your Needs 5th Edition 2006 (http://www.dva.gov.au/health/research/lives_needs/pdf/lives_needs2006.pdf – accessed 24 Jan 2009)

⁹⁴ Australian Bureau of Statistics (2008) 4326.0 - National Survey of Mental Health and Wellbeing: Summary of Results, 2007
(<http://www.abs.gov.au/ausstats/ABS@.nsf/Latestproducts/4326.0Main%20Features32007?opendocument&tabname=Summary&prodno=4326.0&issue=2007&num=&view=> accessed Jan 3 2009)

⁹⁵ Australian Institute of Health and Welfare (2008). Australia's health 2008. Cat. no. AUS 99. Canberra: AIHW:95-6.

9.5 Assessment

This overall assessment is based on a review of all technical and research documents, stakeholder input and public submissions. A summary of themes arising out of both individuals and organisation submissions relevant to *Veteran compensation schemes and mental health* are included in Appendix 1. Rapid literature reviews relevant to topics considered in this section were conducted as follows:

- Appendix 2 PTSD and best-practice treatment.
- Appendix 3 Adjustment disorders and best-practice treatment.
- Appendix 4 Combat exposure and Post Traumatic Stress Disorder.
- Appendix 5 Barriers to mental health care in the ex-service community including stigma.
- Appendix 6 Mental health promotion and literacy programs
- Appendix 7 Interventions to reduce alcohol misuse.

DVA's mental health strategy and support for education of mental health professionals.

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 (The Right Mix, At Ease). 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.

Other countries

Veterans Affairs Canada has a Mental Health Strategy.⁹⁶ It now recognised that as a result of increased operational tempo, the prevalence of psychological and psychiatric-related conditions is increasing among Canadian Forces members and Veterans. In 2002, Veterans Affairs Canada and the Department of National Defence jointly announced a mental health initiative to enhance the services and supports provided to veterans who suffer from operational stress injuries (OSIs) as a result of their service. This was the initial step in developing a Mental Health Strategy which will have the following four goals

- Implementation of a comprehensive continuum of mental health services and policies (including release of web-based materials on nurturing mental health and wellness);
- Building a national capacity to provide specialised care to veterans with a service-related mental health condition. This includes the development of an integrated network of Operational Stress Injuries clinics as well as a network of service providers at the local community level;
- The ongoing development of the Department's National Clinical Centre of Expertise in clinical matters related to mental health;
- Development of strong, collaborative partnerships with other mental health organisations.

⁹⁶ Veterans Affairs Canada Veterans Affairs Canada Mental Health Strategy (<http://www.vac-acc.gc.ca/clients/sub.cfm?source=mhealth/strategy> - accessed 24 Jan 2009).

In the UK, the Ministries of Defence and Health have developed a new community-based mental health service. The first of six regional pilots was recently launched with other pilots at sites across the UK to follow. These mental health pilots will run for two years ahead of evaluation and nationwide roll out. The service is designed to provide regional networks of culturally-sensitive expertise in military mental health to support NHS health professionals. Pro tem, it will expand the Medical Assessment Programme (MAP) at St Thomas' Hospital, London to include assessment of veterans with mental health symptoms with operational service.⁹⁷ The Ex-Services Mental Welfare Society, Combat Stress in the UK is a services charity providing services to veterans suffering from psychological disability as a result of their service. It has a national network of welfare officers, three treatment centres and provides rehabilitative treatment which aims to help the victim cope with their disabilities and improve their quality of life.⁹⁸

The US Department of Veterans Affairs is very active in the treatment of US veterans and has an active research and education program in mental illness - the Mental Illness Research, Education and Clinical Centers (MIRECC).⁹⁹ It does not appear however to have an active mental health strategy with the exception of a suicide prevention program.

In addition, in support of there being a veterans' mental health strategy, the rapid literature review of mental health promotion programs attached at Appendix 6 concluded that there is evidence that both mental health promotion and mental health literacy programs can be effective. They can make a contribution to both the mental health and wellbeing of the community. The evidence base though is still limited and the effects of mental literacy campaigns may also be limited. In addition, the rapid literature review of interventions to reduce alcohol misuse attached at Appendix 7 concluded that, despite methodological shortcomings in the studies, such interventions in the primary care setting have the potential to reduce alcohol misuse.

There is thus support for the conduct of mental health promotion program such as The Right Mix and At Ease.

It is some time though since the release of the Mental Health Policy and Strategic Directions paper in 2001 and the Consultation in 2004. In the meantime the Council of Australian Governments (COAG) has put in place a National Action Plan on Mental Health 2006-2011 and State governments are active in revising their mental health services.^{100 101} The ADF is considering revision and further development of its Mental Health Strategy.

⁹⁷ Ministry of Defence Veterans for defence Military Covenant Factsheet – Compensation (http://rafasudouest.googlepages.com/MILITARYCOVENANTFACTSHEET_2_.pdf - accessed Jan 2009).

⁹⁸ Combat Stress The Need for Combat Stress in today's world (<http://www.combatstress.org.uk/> - accessed 24 Jan 2009).

⁹⁹ United States Department of Veterans Affairs Mental Health Home (<http://www.mentalhealth.va.gov/> - accessed 24 Jan 2009).

¹⁰⁰ Council of Australian Governments (COAG) National Action Plan on Mental Health 2006 – 2011 (http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf - accessed 24 Jan 2009).

DVA has participated in the COAG processes on Mental Health and is planning to update the Mental Health Policy and Strategic Directions paper to ensure it is fully contemporary and aligned with the COAG Plan. This will also be informed by the work of ACPMH (on contract with DVA) to evaluate DVA's Mental Health Initiatives for 2007-10. One aspect of the evaluation is the level of mental health literacy in DVA staff. There have been plans, as yet unrealised to deliver a mental literacy program for DVA staff. Findings of the evaluation will inform whether this should proceed.

It has been suggested that programs aimed at alcohol misuse could be further developed. Operation *Life* was further considered in Section 2 above.

VVCS (including Veteran's Line)

VVCS has made a major contribution to the delivery of counselling services to veterans and very importantly for their families. They have a national network of services which seems to work well. It is an important source of advice on mental health matters to DVA. It is playing an expanding role in delivering services to veterans who are currently serving ADF members and their families and also other ADF members on contract with the ADF. This has been major contribution given difficulties in a number of bases for the Medical Officer or Psychological Support Section to deliver counselling services.

The recently signed MOU with the ADF should improve reporting-back requirements when a member is referred by the ADF. Self-referrals are more problematic as the service being provided to the self-referred member is confidential and not known to the ADF. It is important therefore that duty of care obligations by VVCS counsellors are met in the event that a member is at risk of self-harm or harm to others (in the military environment). Preferably disclosure of confidential information in a duty of care situation will be with the consent of the member.

VVCS is largely staffed with psychologists and some social workers. It has a policy of making referrals to specialist services and treatment programs such as psychiatric assessments for partners and children of Vietnam veterans and PTSD and other programs. Some stakeholders consulted were unsure however, to what extent these referrals were happening.

Recent developments to improve mental health care in the Australian community have occurred through both the Better Outcomes in Mental Health Care and Better Access to Mental Health Care Initiatives of the Australian Government.¹⁰² The latter through Medicare Australia is making possible a new horizon for community access to (subsidised) private counseling services of both psychologists and also social workers. Support through subsidy, however is only provided for the delivery of evidence-based treatments only. In addition there are restrictions such that services can only be

¹⁰¹ Victoria's Mental Health Services. Because mental health matters: a new focus for mental health and wellbeing in Victoria

(<http://www.health.vic.gov.au/mentalhealth/reformstrategy/index.htm> - accessed 24 Jan 2009).

¹⁰² Australian General Practice Network Better Outcomes to Mental Health Care Initiative (<http://www.primarymentalhealth.com.au/site/index.cfm?display=15130> - accessed Jan 9 2009)

subsidised if 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.

Focused Psychological Strategies are specific mental health care treatment strategies derived from evidence based psychological therapies. They are described on the website of the Clinical Research Unit for Anxiety and Depression.¹⁰³ They have been shown to integrate the best research evidence of clinical effectiveness with general practice clinical expertise. While these are derived from cognitive behaviour therapy and interpersonal therapy, they are not the same as 'fully fledged' CBT therapy or interpersonal therapy. Rather, they consist of a range of specific strategies drawn from CBT and interpersonal therapy. These include eg psycho-education; behaviour modification; exposure techniques; activity scheduling; and relaxation techniques.

Psychological Therapy: It is recommended that cognitive-behaviour therapy be provided as well as psycho-education.¹⁰⁴ However, other evidence-based therapies - such as interpersonal therapy - may be used if considered clinically relevant.

It is important therefore that work done at VVCS registered psychologists is restricted to *Focused Psychological Strategies* and only clinical psychologists engage in *Psychological Therapy*. VVCS should be able to demonstrate that this is happening or if not, what steps they are putting in place to conform to this practice.

It is also important that VVCS clients can be confident that if a DSM-IV mental conditions if present it will be not only diagnosed but also treated. This will frequently require prescription of psychotropic drugs and therefore medical involvement. It is important therefore that there should be some level of involvement of psychiatrists or GPs with interests in mental health who can prescribe such drugs in all VVCS centres. In general, multidisciplinary care is highly desirable in the delivery of community-based mental health care. While it is envisaged that a psychiatrist or suitable GP would have an involvement in care at VVCS, this would not necessarily be a major one and could take the form of shared care, participation in case conferences and staff education.

Hard-to engage veterans

The rapid review of the research literature on Barriers to mental health care in the veteran community concluded that barriers to care were more widespread in veterans who had mental health problems either during or after service. These barriers chiefly

¹⁰³ Clinical Research Unit for Anxiety and Depression. Welcome to GP care <http://www.gpcare.org/> accessed Jan 9 2009).

¹⁰⁴ Better Access to Mental Health Care – Psychological therapy and Focussed Psychological Strategies (FPS) services (http://www.health.vic.gov.au/communityhealth/downloads/mbs/gps/mental_health_pat_links_gp.pdf - accessed Jan 9 2009)

referred to veterans' perceptions of their own predicament and self-management approaches which was attributed to perceived 'uselessness' of available treatments.

There were also barriers around knowledge of what services were available and how this information was disseminated. As the literature on serving members indicated, the research in this review reveals that only a minority of individuals with mental health problems appear to be seeking help. In addition to access, health literacy and perceptions of treatment efficacy, the findings point to stigma being a determining factor.

The Pathways to care study also outlined a number of reasons why veterans with DVA disability pensions for mental conditions do not seek care.¹⁰⁵ These included that they resisted accepting that they had a mental health condition, were embarrassed talking and seeking help for mental health problems and had little knowledge of mental conditions and services available. They also reported that had not been pleased with previous experience of contact with health practitioners and that mental health services were not available locally.

Barriers to care are obviously substantial and need to be addressed. The Lifecycle project targeting 'hard to engage' ex-service members is addressing this issue. It is currently considering a number of options how it might be possible to engage with this group - see Sections 9.2.4.

Recommendation (2.5) for a Keeping in Touch program post-discharge to the ADF was proposed in Section 5. It is one option for an Outreach program that is important not only at Transition but also during later years. It could be a vehicle to promote a variety of mental health and wellness programs and events that may of interest to veterans and their partners.

A number of stakeholders noted that veterans do not always want to keep in touch with either DVA or the ADF. This is associated with their general orientation of disengagement. Alongside initiatives to re-engage these veterans, reasons for their disengagement should be better understood. A number of issues that are pertinent to these reasons are identified in earlier Sections, ones around the compensation claim process particularly so. The Recommendations in Part B of the Study propose how these issues might be addressed. They are aimed in part at reestablishing the relationship that the veteran has with both the DVA and the ADF.

PTSD - prevalence

The prevalence of PTSD cited in relevant studies requires some interpretation depending on the psychometric instrument used. In addition, prevalence levels may refer to deployment or to total life events, and to current or lifetime levels of PTSD. Comparison of levels with other groups also needs to be interpreted. They are usually all other members of the population after age and sex-adjustment or a group of military eligible but not deploying to the relevant theatre of war.

¹⁰⁵ Hawthorne G, Hayes L, Kelly C et al (2004) Pathways to care in veterans recently compensated for a mental health condition, Australian Centre for Posttraumatic Mental Health:1-261.

Summary tables making comparison are set out below. Full tables are attached in Appendix 4. The table, over, shows prevalence of PTSD for a number of conflicts in which Australian troops have been involved. The Odds Ratio estimate how many times the levels are greater for troops than the comparison group. The 95% Confidence Interval (95% CI) estimates the level of uncertainty around the estimation of the Odds Ratio. Odds ratios for PTSD are generally substantially (and statistically significantly) higher for the Australian troops which deployed than the comparison population.

There is marked variation in the level of DVA disability pensions (compensation payments) by theatre of war. These have been 29.0% for Vietnam, 3.0% for First Gulf War, 23.9% for Rwanda, 1.1% for East Timor and 0.4% for Iraq/Afghanistan (combined) – see Section 7.5.

Summary of PTSD prevalence data for Australia veteran populations

Conflict	Instrument	Comparison	Prevalence	Prevalence in comparison	Odds ratio (95 % CI)
Korea 1950-56	PCL \geq 50	Australian males, similar age	25.6%	4.6%	6.6 (5.1-8.6)
Vietnam 1964-72	Diagnostic Interviews: Lifetime PTSD Current PTSD measure 1 Current PTSD measure 2	None	11.7%-20.9% 11.6% 8.1%	None reported	
Persian Gulf 1990-91	Diagnostic Interviews: Symptoms newly present after Gulf War Symptoms present in previous 12 months PCL-S \geq 50	Other ADF, eligible not deployed	5.4% 5.1% 7.9%	1.4% 1.7% 4.6%	3.9 (2.3-6.5) 4.1 (2.4-7.2) 2.0 (1.5-2.9)

It is also difficult making comparisons between PTSD levels for Australian troops deploying compared with troops deploying from other countries for similar reasons to those noted above. In addition studies that potentially are comparable because the same psychometric measure has been used may refer to different theatres of war – see table below.

Prevalence in veteran populations using PCL with cut-off score \geq 50

	UK	Australia	USA
Korean		25.6%	
Persian Gulf		7.9%	
Iraq	4%		12.2%-16.6%
Afghanistan			6.2%
Afghanistan & Iraq			9.0%

Surprisingly, in some international studies PTSD levels after deployment may be less than before deployment.

While it may be difficult to interpret both levels and comparison of levels for PTSD, there is little doubt that levels of PTSD are elevated in Australian veterans.

PTSD - treatment

It is unclear whether Australian veterans with PTSD are getting best treatment. Best practice (evidence-based) treatment for early onset cases is now well recognized. It consists of trauma-focussed treatments - Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR).¹⁰⁶ These can reduce PTSD symptoms, lessen anxiety and depression and improve a person's quality of life. Drug treatments should not be initially considered unless the trauma-focussed treatments are insufficient to substantially reduce the person's distress. Where medication is considered for the treatment of PTSD in adults, Selective Serotonin Reuptake Inhibitor (SSRI) antidepressants should be the first choice for both general practitioners and psychiatrists.

Not all patients with early-onset PTSD receive this evidence-based treatment. One well-informed estimate is that only around 30% are receiving such treatment. This may be because this treatment by its nature is stressful and requires substantial compliance and engagement which may not be possible for patients with PTSD. It may also be that practitioners with both skills in trauma-focused therapies and able to prescribe SSRI antidepressants are not widely available. Some with skills may also find it demanding and time-consuming (80 minutes as a minimum is recommended).

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. Some are also not suitable. While programs are available for Younger Veterans with PTSD at some centres such as the Veterans Psychiatry Unit PTSD Program at the Austin and Repatriation Medical Centre, Melbourne, they are not available at others.

Given these uncertainties, the conduct of a strategic review of service-related PTSD programs in Australia would be timely.

Families of 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.¹⁰⁷

In addition families may have more insight than the veteran into the difficulties they are experiencing with mental health problems. The Pathway to care study described above, confirms the low levels of mental health literacy in veterans, even among those with compensable mental conditions.

¹⁰⁶ Australian Centre for Posttraumatic Mental Health (2007). Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder. ACPMH, Melbourne, Victoria.

¹⁰⁷ Morbidity of Vietnam Veterans - A Study of the Health of Australia's Vietnam Veteran Community (<http://www.aihw.gov.au/publications/phe/mvv/index.html> - accessed 27 Jan 2009)

It is important therefore that families receive needed services for themselves. VVCS is the principal service in this regard (as well as DCO for veterans who are still ADF members). Families should also be involved in relevant events and services (treatment or other) where this is possible. Recommendation 2.3 nominates transition-out of the ADF as such an event. The proposed Keeping-in-Touch program (Recommendation 2.5) should particularly involve families.

Research

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

9.6 Recommendations

Recommendation 9.1: DVA's mental health strategy beginning in 2001 has led to the development of a number of community mental health promotion programs. DVA intention to consider how this strategy might be further developed is strongly supported. Programs for suicide and alcohol misuse require particular attention. The ACPMH have been contracted by DVA to evaluate its Mental Health Initiatives for 2007-10 and this will be very useful in identifying other areas.

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

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

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

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

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

Appendix 1 Emergent themes from public submissions

DISCLAIMER: The views expressed in this Appendix are those expressed by the individuals and groups making submissions. They do not represent the views of the author. They represent however a range of perceptions and insights relevant to the study and are an important input.

The following themes are derived from submissions for the 'Independent Study into Suicide in the Ex-Service Community' collected between August and October 2008. Submissions were collated and analysed according to two key sources; individuals and organisations. Individual submissions came from current serving members and veterans, and partners and/or family members of suicides, all of whom have had some dealings with DVA. Organisational submissions included independent psychologists, members from key agencies and government service providers. The submissions are presented according to individual and organisation key points and the proposals.

The submissions highlight important shortcomings in DVA processes and support services for veterans. They offer important insights into the lived experience of veterans suffering mental health conditions and the family members of veterans who have committed suicide. The topic of suicide in the military/veteran community is complex and as demonstrated by the submissions, anchored in a multiplicity of stressors.

1 Transitional services

Key Points – Individual

As expected the submissions relating to this topic drew on a variety of unfortunate events and accounts of stressful experiences with mental health problems and suicide. While reflections on the transition services provided by the ADF were not greatly represented, nonetheless it was expressed that there was not enough assistance, particularly regarding re-training, for discharged members in meeting the needs of a civilian environment. This referred to both socially, culturally and occupationally. It was observed that accessing meaningful employment (beyond simply security work) was difficult due to lack of preparation by the military, for instance some apprenticeships fall short of meeting civilian trade requirements and there seems to be no provision for this by the ADF post discharge. Added to this, depending on the role undertaken for the military, members can be at a real loss, socially and in terms of employability, when discharged. Employment opportunities may be limited, especially if they do not have a higher degree.

It was also noted that the precursor to discharge, which can often involve a progress reduction of or removal from duties, which some felt amounted to demotion, was a humiliating and upsetting experience.

After discharge, there were reports of ongoing isolation and lack of support. Members reported feelings of being ‘cut loose’, or if injured ‘cut off’. There was a tone throughout the submissions that the experience of transitioning out lacked dignity. This appears inconsistent with an institution which valorises values such as dignity.

Submissions often reported an absence of support (this applied across all themes) and that the discharge process itself involves numerous steps which can affect the mental health of the individual, who amongst other things might have to contend with feelings of ‘letting down mates’ when discharged.

Key Points – Organisational

From an organisational perspective, the only comments appeared to relate to members are not provided with adequate financial, medical and social support prior to discharge.

Proposals - Individual

Individual submissions were more forthcoming in suggestions for ways to improve transition services in the ADF. Among these was the recommendation that more be done to address the shock of being discharged. This would also include greater efforts at re-training for civilian life and mandatory pre-discharge counseling.

It was also proposed that there should be greater acknowledgement for the contribution of all members, not just those who served overseas.

Proposals - Organisations

A key recommendation from the organisation submissions was that relevant departments develop a cooperative approach for transition management. This also included the involvement of family members who are regarded as being pivotal to the success outcomes of transitioning back into civilian life as well as a fruitful resource for monitoring the mental health condition of the member. It was suggested that programs for returning military (and their family) be given on a mandatory basis rather than on a request basis. The need to identify those who might be slipping through the cracks was an overarching concern for organisations.

Canada’s ‘third location’ was also raised as a model which could be reviewed for suitability for Australian troops.

2 Multiplicity of military compensation schemes

Key Points – Individual

There was unsurprisingly, few submissions from individuals referring to the multiplicity of compensation schemes. Observations relating to this theme chiefly referred to the challenges of lodging claims and difficulties receiving advice, from a single rather than numerous sources, regarding the multiplicity of legislation. It was

noted that disabilities can be covered by several schemes and making sense of this often relies on the assistance of advocates.

Key Points – Organisational

No relevant submissions

Proposals - Individual

No relevant submissions

Proposals - Organisations

No relevant submissions

3. Operation of military compensation schemes, DVA

Key Points – Individual

The operation of military compensations schemes and the DVA was the source of malcontent for individuals and their families. The overall experience was characterised as being one of frustration, anguish, confusion and leading to feelings that vital information was being ‘hidden’ by DVA staff. It was reported that channels of and accessing to information was complicated and protracted. This was increasingly difficult to manage if the member had a mental health problem. Furthermore, the event of an applicant’s first attempt being rejected was consistently reported as an upsetting experience, perceived as debilitating and unresolved.

There were claims of numerous rejections of claims. As this progressed so too did an individual’s frustration and despair. Cases which reached final arbitration took many months and anguish before a decision was delivered. There were beliefs that the ‘goal posts’ were kept deliberately moving, particularly the closer one got to resolution. Moreover, there was also little support provided to individuals whose claims were rejected.

Related to this, DVA staff were the subject of much criticism in the submissions. This mostly referred to attitudinal approaches rather than knowledge (this provides an interesting contrast to the ADF submissions on DVA staff). Oftentimes it was reported that DVA staff were not only unsympathetic to the plight of veterans, but either tacitly or explicitly would, it was believed, subject their mental health conditions to incredulity, ridicule and disbelief. As a result, the veteran was left feeling like they were being treated suspiciously.

In the case where the injury was not deemed to be permanent, there was a requirement that forms be submitted annually, requiring specialists’ signatures. This was a strain for veterans who lived in remote areas. Also the use of DVA/MCRS selected doctors was considered unfair because it was felt they lacked the level of intimacy with the veteran’s condition, especially if it had been an ongoing issue. While GP reports can be submitted, it is the determination of the DVA doctor which counts. For this reason there was a stated lack of trust in DVA/ MCRS specialists, who it was felt were serving the interests of the organisation, rather than the veteran.

Financial support post injury was another area which was reported as inadequate. In the event DVA refused to cover medical expenses, individuals were reliant on bulk billing by their specialists and GPs. There was often financial hardship encountered as a result of the claims process. In such cases, there was a need to use lawyers which severely affected the veteran's financial stability. Many members reported suicidal thoughts as a result of feeling like a burden on their families (not being able to work and often needing care) and that suicide was a way of providing relief for their families.

In addition to compensation claims, it was reported that there was poor management of services (i.e. homecare). In fact, housing itself appeared to be a problem in the intervening period before DVA assistance. Some of the individual submissions reported experiencing homelessness while awaiting DVA housing assistance.

Given many of the submissions were made by family members of deceased veterans, the impact of the process, including all the points noted above, had a considerable impact on the families of members.

There were variable experiences with ESOs reported yet the client liaison unit was considered helpful in providing accurate and timely information.

Key Points – Organisational

As with the ADF submissions, a key concern for organisations related to limitations around access to programs for non veteran status individuals. This it was claimed to be a major problem for ex-service members who had mental health problems. In addition of multiple agencies which leads to confusion in an already vulnerable individual, delays in claims and any rejection or suspension of medical treatment contributed to the stresses of this process.

Organisations commented on the need to undergo ongoing reassessments by MCG and/or ComSuper was frustrating, compounded by the attitude of delegates of DVA/MCRS/ComSuper, which it was believed treated veterans as 'lairs'. There was a belief that some delegates were seemingly prone to rejecting claims (based on minor/obscure comparisons in specialist reports).

Proposals - Individual

It was recommended that a more streamlined process be instituted which included a reduction in the amount of medical appointments an individual is required to attend. Commensurate with this, it was proposed that there be less 'judgment' on behalf of DVA staff.

The Client Liaison Unit was positively regarded as was other forms of advocacy.

Proposals - Organisations

Organisations proposed an audit on rejected claims should be conducted and to determine any links to or patterns among delegates and rejected claims. Importantly, priority needs to be given to processing claims involving mental health issues.

It was recommended that programs be made available in each state and to peacetime service persons as well as veterans and that there be a monitoring system for an 'at risk' group is set up while DVA claims are processed. This would enable closer case management and follow up for vulnerable individuals.

4 Barriers to care

Key Points – Individual

The category of 'barriers to care' appeared to cross over a number of areas in the submissions. Barriers included evidence of a military stigma around weakness. While this predominantly related to attitudes about what it is to be a 'good' soldier and a member of a team, negative attitudes and resultant harassment was reported as being largely generated in the higher ranks. Because of this members were not seeking help for mental health problems whilst, but this had a flow-on affect if they were then discharged.

Several submissions cited incidences of undiagnosed PTSD which led to delays with compensation claims.

There were limited or no mental health services in remote areas.

Regarding the services provided, it was commented that there was a lack of counseling from professionals who understood the lived experience of the veteran. It was felt the use of younger, civilian psychologists meant there was no background of relatedness and therefore might discourage veterans using the service.

Reports of marital problems were seen as a key catalyst to a suicide attempt. However, many veterans did not seek help in this area due to pride.

Key Points – Organisational

The only organisational response regarding this theme related to the problem of veterans acknowledging they have a problem in the first place in order to seek help. This was identified as a key hurdle to overcome.

Proposals - Individual

It was proposed that members should be provided with more training about PTSD and mental health problems which arise during service. This would improve identification and support amongst coworkers. This would ameliorate the 'collective mentality' in the ADF which reproduces stigma. The caveat to this is that education should not be delivered by a doctor or psychologist but rather a veteran, who would be responded to more positively as a role model. There should also be the provision of annual talks by ESOs

Veterans should be encouraged to accept their injuries regardless of whether they are significant at the time. This could be of benefit in terms of them having treatment readily available should problems arise in the future.

Proposals - Organisations

Funding of current programs for expansion and improved publicising. Related to this, suicide prevention should focus on programs which reduce the stigma attached to mental health problems. Finally, organisation submissions recommended that members who are identified as being 'at risk' at the time of claims should be referred to a counseling service.

5 Health of veterans

Key Points – Individual

A recurring theme in the submissions was that the conditions of being a combat soldier can produce depression and suicide, particularly in the longer term. There was an over-representation of reports which expressed feelings of depression, anxiety, suicidal thoughts and multiple suicide attempts, which in many cases (if unsuccessful) resulted in admittance to a psychiatric hospital. These appeared to be precipitated by feelings of solitude due to broken marriages and feeling like a burden on families, particularly if the veteran was no longer able to provide financially for his family.

Some submissions came from members whose participation in the ADF was of a peacetime basis. For them there were problems accessing medical treatment card. There were also comments made regarding being affected by pain and having to take multiple medications, all of which led to restrictions on participating in life in ways previously accustomed to. This also refers to difficulties in integrating back in to the civilian community and lack of employment opportunities compounds existing mental health conditions. It was reported that DVA surgery triggered incapacitation both pre and post surgery which resulted in significant financial loss for the veteran and feelings of desperation and hopelessness.

Key Points – Organisational

Organisations highlighted the existence possible discrepancies in veteran suicide figures as the incidence of suicide in peacetime servicemen is lesser known and does not attract DVA (and media) involvement. Furthermore, it was reported that suicides are not recorded as cause of death in DVA and MCRG databases. It was also claimed that suicide in members may not only result from wartime activities, but can result from the death of a friend either via accident, bullying/harassment, family problems and/or the prospect of a medical discharge.

Drug and alcohol abuse was consistently reported by organisations as well as individuals. International research consistently demonstrates the link between suicides in the military and veteran population and relationship breakdowns. Studies have shown other stressors to be financial and legal problems but failed relationships with spouses or intimate partners is a high risk factor for suicide.

Proposals - Individual

No relevant submissions

Proposals - Organisations

HeartHealth is a proposed program offering a combined exercise and seminar program for veterans and their partners over one year. Seminars would concentrate on providing psycho-social education, development of strategies to address common issues around wellness, networking and support opportunities. The program is aimed at ex-military personnel who separated from the service between five and eight years post. The program is also designed to be repeated two years after the original attendance. A key difficulty is that some disabilities do not become apparent until many years later. This program aims to reduce/manage the incidence of disability related claims as well as psychological and physical health of veterans.

6. Mental Health services for veterans' families

Key Points – Individual

VVCS were regarded as not being manned by mental health care specialists qualified to deal with suicides. For families, both the years leading up to and the suicide itself have profound affects. Family members are in such cases forced to deal with erratic moods and behaviours, financial problems, and sometimes multiple suicide attempts (most invariably leading to success at some point). This occurs in addition with dealing with a close family member who seemingly has altered irrevocably from their military encounter.

Wives and children are also at a greater risk of stress, depression and suicide. Many submissions emphasised the stress with having to advocate on behalf of a veteran, in some cases this resulted in depression and suicide attempts in wives, partners, mothers and sometimes the children of veterans. There were reports of suicide of children (and several attempts by wives) of veterans. This may in part be due to feelings of guilt by family members who feel they did not help or do enough to prevent the suicide of the veteran. While the DVA attempt to support the veteran, it is often the family who suffer as the veteran ignores his problem. There were often reports of family violence, often having a long history since discharge. The experiences of families members in such situations is inadequately accounted for as members attempt to cover up the existence of family and/or alcohol/drug problems. It was felt by some of the family submissions that there is a lack in official agencies seeking input from family members.

Family members felt they were unable to get adequate or satisfactory answers about the veteran's suicide. Many simply sought information about what aspect of the military service may have triggered the depression or PTSD which led to the suicide.

Key Points – Organisational

No relevant submissions

Proposals - Individual

Consistent with the individual submissions regarding the impact on families, there was the suggestion that consideration should be given to partners, parents and children of veterans with mental health problems and PTSD.

Proposals - Organisations

In support of the points made in the submissions, organisations' recommended that authorities recognise the impact families can have on veterans (and active service personnel) which can have both positive and negative effects on the mental health of the ex-service person. More research to be done on interpersonal relationships and moderator factors between family (partners) and suicides/attempted suicides of both service and ex-service members.

7 Relevant perceptions about the ADF and their effects

Key Points – Individual

When it came to stigmatising attitudes and behaviours it was reported that leaders were key protagonists. The attitudes for instance that members seeking help for mental health problems were perceived as milking the system, of leaders was considered pivotal as lower ranks will adopt their viewpoint regardless. This reproduces the culture of stigma and bullying across all ranks. Furthermore, it was reported that internal jealousies around deployment led to mistreatment and bullying or attempts at humiliation by other members. This underscores dissonance between perspectives from 'the ground' and official reports of ill treatment from superiors and how mental health problems are dealt with internally.

Proposals - Organisations

Organisations suggested counseling is a requirement for phenomena which are not direct contact events, such as after exposure to human remains which is a more hidden side of service operations but can equally have an impact on the mental health of a serviceperson.

Appendix 2 Rapid literature review of PTSD and best-practice treatment

Post-Traumatic Stress Disorder (PTSD) is defined as a “long-lasting anxiety response following a traumatic or catastrophic event” that typically involves death, serious injury or threat to the personal integrity of the self or others.(Clinical Research Unit for Anxiety and Depression 2007) PTSD usually develops within 3 to 6 months of exposure: a more immediate and transient response is termed ‘acute stress reaction’(Clinical Research Unit for Anxiety and Depression 2007); and long-lasting reactions that first appear more than 6 months after exposure may be diagnosed as ‘delayed onset PTSD’.(Andrews, Brewin et al. 2007)

Symptoms of PTSD (and acute stress reaction) may include:

- *Images, dreams, or flashbacks of the traumatic event*
- *Avoidance of cues which act as reminders of the traumatic event*
- *Amnesia about important aspects of the traumatic event*
- *Intense arousal and anxiety on exposure to trauma cues*
- *Depressed or irritable mood*
- *Social withdrawal*
- *Concentration and memory difficulties*
- *Nightmares and disturbed sleep*
- *Being easily startled* (Clinical Research Unit for Anxiety and Depression 2007)

Studies suggest that 50% to 80% of people in developed countries experience PTSD-candidate events: yet only eight to ten percent of exposed persons develop PTSD, with females being twice as likely to develop PTSD as males.(Clinical Research Unit for Anxiety and Depression 2007; Stein, Seedat et al. 2007) The likelihood of onset of PTSD varies by the type of experience, with rape most likely to induce PTSD (in both male and female victims), followed by combat experience and physical abuse.(McFarlane 2004) Depression, generalised anxiety disorder, social phobia, alcohol abuse and drug addiction are common comorbidities alongside PTSD.(McFarlane 2004) (Australian Centre for Posttraumatic Mental Health 2007)

Military studies

Estimates for the incidence of combat-induced PTSD vary according to the theatre of engagement. The estimated risks for active soldiers in current conflicts are 18% for Iraq and 11% for Afghanistan.(Litz 2007) At least 15% of US soldiers serving in Vietnam met the criteria for PTSD during or after their service.(McFarlane 2004)

A family history of psychopathology and prior individual trauma increase the risk of developing PTSD, while combat injuries and post-deployment factors of low social support and high exposure to stressful situations may also increase risk and slow recovery.(Litz 2007) Apart from combat injuries, these same risk factors operate in the general population (Australian Centre for Posttraumatic Mental Health 2007).

PTSD-related behaviours such as social avoidance, anger and irritability tend to reduce the post-military employment prospects of sufferers.(Resnick 2008)

Treatment of PTSD

The *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder* (Australian Centre for Posttraumatic Mental Health 2007) recommend two types of first line psychological interventions: trauma-focused cognitive behavioural therapy (TFCBT), and eye movement desensitization reprocessing (EMDR). Subsequent (but not first line) drug treatment using selective serotonin reuptake inhibitors (SSRI) may be considered where psychological therapies are insufficient or refused. (Australian Centre for Posttraumatic Mental Health 2007)

Both TFCBT and EMDR treatments are recommended in a Cochrane Review of psychological treatments of PTSD.(Bisson and Andrew) Drug treatment with SSRIs is recommended in a separate Cochrane Review of pharmacotherapy for PTSD.(Stein, Ipser et al.)

TFCBT involves education about trauma, stress management skills, cognitive therapy and exposure therapy.(Litz 2007) EMDR as it is currently practiced includes most of the core elements of TFCBT plus eye movement desensitization techniques. (Australian Centre for Posttraumatic Mental Health 2007) The *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder* state that 8 to 12 therapy sessions are normally sufficient. (Australian Centre for Posttraumatic Mental Health 2007)

However, at least 80,000 US Vietnam veterans continue to suffer debilitating problems from war-related PTSD decades after repatriation.(Rosenheck, Stolar et al. 2000) The enduring nature of war-related PTSD, once chronic, would underline the urgency of timely and appropriate intervention responses to currently serving personnel.(Litz 2007)

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Appendix 3 Rapid literature review of Adjustment disorders and its treatment

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), adjustment disorders are stress-induced responses excluding bereavement that significantly impair social or occupational functioning for a period not exceeding 6 months beyond the stressful event or its aftermath.(Bruinvels, Rebergen et al.)

However, this apparently time-limited illness is strongly associated with discharge from military service. US military studies show that mental disorders are the leading cause of hospitalisation in men, and second cause after pregnancy in women. In turn, around 45-50% of service personnel hospitalised for mental disorders leave the military within 6 months, which is four times the exit rate of all other illness categories combined. Hoge et al (2005) found that the most common diagnosis within mental disorders was adjustment disorder (40%), followed by alcoholism and substance abuse (26%). Personality disorders and misconduct were frequently co-present with diagnoses of adjustment disorder, meaning that adjustment disorder per se may not have been responsible for service discharge in all cases.(Hoge, Toboni et al. 2005)

A separate study of military personnel psychiatrically evacuated from Iraq showed adjustment disorders to account for 37.6% of evacuations, with only 5% of evacuees returning to the same theatre of operations.(Rundell 2006) The rate of service discharge for psychiatric evacuees was not reported.

These high workplace attrition rates are reflected in the general population, where 20% of patients diagnosed with adjustment disorder may not return to work within 12 months.(Bruinvels, Rebergen et al.) Usual interventions for adjustment disorders include antidepressant treatment, cognitive behavioural therapy, relaxation techniques, and employee assistance programs.(Bruinvels, Rebergen et al.)

Civilian studies of adjustment disorder rehabilitation suggest that recovery is optimized by:

- Timely and frequent consultations.(Nieuwenhuijsen 2003)
- Collaborative planning between clients, physicians and workplace management.(Nieuwenhuijsen 2003) (Foreman, Murphy et al. 2006)
- The adoption of pro-active strategies wherein clients construct a personalised, graded recovery plan.(van der Klink 2003; van der Klink and van Dijk 2003)

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Appendix 4 Rapid literature review of PTSD and deployment

Introduction

Posttraumatic stress disorder (PTSD) can occur following the experience, or witnessing, of life-threatening events or violent personal assaults. Most people exposed to events that have the potential to cause PTSD experience some of the symptoms in the days and weeks following the event but not all will develop PTSD. Available data suggest that about 8% of men and 20% of women go on to develop PTSD. (<http://www.athealth.com/Consumer/disorders/ptsdfacts.html>) Research suggests that among those who go on to develop PTSD, approximately 30% develop a chronic form that persists throughout the individual's lifetime. Chronic PTSD is most often characterized by periods of symptom exacerbation and remission or decrease, but for some individuals symptoms may be unremitting and severe. (Occupational and Environmental Health Unit: Monash University 2003).

PTSD is not a new disorder: a PTSD-like disorder was known as "Da Costa's Syndrome" in the American Civil War and there are accounts of PTSD symptoms in the medical literature relating to combat veterans of World War II and Holocaust survivors. However, careful research and documentation of PTSD only began after the Vietnam War. Since then, PTSD has been observed in all veteran populations that have been studied (e.g. Korean conflict, Persian Gulf War, and United Nations peacekeeping forces deployed to other war zones). (<http://www.phobics-awareness.org/ptsd.htm> accessed 25 November 2008)

The aim of this review is to determine the PTSD rates in Australian, UK and US military personnel returning from deployment in Korea, Vietnam, the Persian Gulf, Bosnia, Iraq and Afghanistan. The first section of the review gives a brief overview of the main ways in which PTSD has been measured in the studies included in this review. It also considers the validity of the non-interview PTSD questionnaires.

Measuring PTSD

1 Face-to-Face Interviews

Diagnostic Interview Schedule (DIS)

PTSD module from the standardized clinical Diagnostic Interview Schedule of the American Psychiatric Association (November 1987 version). (O'Toole, Marshall et al. 1996) It does not require history of symptoms. In addition, it ascertains when symptoms of a disorder first appeared and were most recently experienced, and asks whether a doctor was ever consulted about the symptoms. DIS-IV is based on the DSM-IV and incorporates some of the lessons learnt from the development of the Composite International clinically trained interviewers to administer or score the schedule. It offers a lifetime Diagnostic Interview (CIDI). (<http://epi.wustl.edu/dis/dishisto.htm> athealth)

Composite International Diagnostic Interview (CIDI)

The CIDI was developed by the World Health Organization (WHO) and the former United States Alcohol, Drug Abuse and Mental Health Administration. It is a comprehensive, fully structured diagnostic interview for the assessment of mental disorders and provides (by means of computerised algorithms) lifetime and current diagnoses according to the accepted definitions of ICD-10 and DSM-III-R. The paper-and-pencil CIDI can be administered by trained lay interviewers.

(<http://www.crufad.unsw.edu.au/cidi/discuss.htm>) The complete CIDI comprises 11 modules. (Occupational and Environmental Health Unit: Monash University 2003)

AUSCID-V

A standardized psychiatric diagnostic interview for Vietnam-related PTSD derived from the PTSD module of the Standardised Clinical Interview for DSM-III-R. (O'Toole, Marshall et al. 1996)

2 Self-Complete Questionnaires

Mississippi Scale

This is a self-complete questionnaire with high face-validity, but it may be vulnerable to manipulation by the person completing the questionnaire. Lyons et al (1994) found that the scores of individuals instructed to respond 'as if' they had PTSD did not differ from the scores of veterans with PTSD. Although veterans who were diagnosed as having PTSD had significantly higher scores than those who did not meet diagnostic criteria for PTSD, the mean score for all groups (veteran and non-veteran) exceeded the originally recommended diagnostic cut-off score of 107. A cut-off score of 121 was found to best differentiate veterans with PTSD from veterans who did not meet diagnostic criteria for the diagnosis. (Lyons, Caddell et al. 1994)

Posttraumatic Stress Disorder Checklist (PCL)

This is a self-complete rating scale for assessing the 17 DSM-IV symptoms of PTSD. Diagnostic utility was determined by using the PCL scores to predict PTSD diagnosis derived from the Structured Clinical Interview for DSM-III-R (SCID). There are three versions. The PCL-M is a military version with questions that refer to "a stressful military experience". The PCL-C is a general civilian version that is not linked to a specific event. Its questions refer to 'a stressful experience from the past'. The PCL-S is a non-military version that can be referenced to any specific traumatic event. The PCL-S allows the respondent to nominate the criterion event and subsequent questions refer to the stressful experience". The same standard scoring method applies to each version.

A total score is computed by coding the five possible responses to each question as 1(not at all)-2-3-4-5(extremely) based on the extent to which the symptoms have been experienced over the last 30 days and then summing the results across 17 questions. Possible scores range from 17 to 85. (Occupational and Environmental Health Unit: Monash University 2003). Two cut-off scores (≥ 45 and ≥ 50) have been used to

indicate a diagnosis of PTSD. There is also a Symptom Cluster Method (SCM) of scoring. Experiencing, to a moderate degree, at least one Intrusion symptom, at least three Avoidance symptoms and at least two Hyperarousal symptoms is taken to indicate the presence of PTSD. (Ramchand, Karney et al. 2008)

Posttraumatic Stress Reaction (PTSR)

This was a variable created to measure PTSR in UK military populations. It was created from responses to a 50-symptom checklist. A diagnosis of PTSR was indicated by the experience during the past month of:

- One or more symptoms on each of four groups of Intrusive Thoughts, Avoidance, Arousal, Irritability); and
- Two or more of the seven symptoms of Associated Behaviours.

Primary Care PTSD (PC-PTSD)

The Post-Deployment Health Assessment (PDHA) and the Post-Deployment Health Reassessment contain the primary Care-PTSD (PC-PTSD). It contains a four-item subscale of the PCL with binary (yes/no) response options. Answering yeas to two of the four items is taken to indicate the presence of PTSD.(Ramchand, Karney et al. 2008)

Screen for Posttraumatic Stress Symptoms (SPTSS)

On this checklist, participants rate the frequency that 17 events happen to them on an 11-point Likert type scale (0=never, 10=always). To be regarded as symptomatic respondents have to indicate a score of ≥ 5 on:

- one or more of the Re-experiencing items;
- three or more of the Avoidance items; and
- two or more of the Arousal items.

3 Validity of the Measures

According to Ramchand et al (2008), the measurement techniques for identifying PTD vary in the extent to which they identify caseness (i.e. those who have PTSD and those who do not). Generally, validity is determined on two dimensions:

1. Sensitivity – the proportion of persons with PTSD who are correctly identified; and
2. Specificity – the proportion of persons who do not have PTSD who are correctly identified as not having PTSD.(Ramchand, Karney et al. 2008)

Diagnostic interviews are considered to be the ‘gold standard’ and the validity of other measures is shown in Table 1.

Table 1 Validity of self-complete questionnaires for measuring PTSD

Technique	Sensitivity	Specificity
PCL – Symptom Cluster Method	1.00	0.92
PCL ≥ 50	0.60	0.99
SPTSS	0.94	0.60
PTSD Symptom Scale (PSS) $\geq 14(a)$	0.91	0.62
PC-PTSD	0.91	0.72

Source: Ramchand, Karney, Osilla, Burns, et al (2008)

Prevalence of PTSD

1 Australia

Korea

Australian military personnel served in Korea from 1950 until 1956 (ceasefire was in 1954). Survey data were collected using a postal questionnaire from 5,564 male veterans (91% response rate) aged over 65 and above, and 1,390 comparison group made up of a sample of Australian males aged 65 and above (92% response rate). Veterans were six to seven times as likely to report symptoms of PTSD and these differences were statistically significant (Table 2). Veterans reporting experiencing heavy combat during Korea were 15 times more likely to meet criteria for PTSD. (Sim, Ikin et al. 2005)

Table 2 Australia: PTSD in Korean War veterans in 2004 (males)

Measurement (a)	Prevalence		Adjusted (b)	Multivariate Adjusted (c)	
	Veterans	Comparison (d)	OR	OR	95% CI
PCL \geq 45	32.5% 1,807/5,564	7.1% 99/1,390	6.16	5.89	4.74-7.32
PCL \geq 50	25.6% 1,426/5,564	4.6% 64/1,390	6.82	6.63	5.09-8.63

Source: Sim, Ikin and McKenzie (2005)

Notes:

(a) A cut-off score of \geq 50 is a more stringent criteria than \geq 45.

(b) Adjusted for age at the time of the study (current age)

(c) Adjusted for current age, education, marital status, and country of birth.

(d) In the original the number of respondents was shown as 1,395; it has been changed to agree with the text.

According to the report:

‘Domestic experiences were the most commonly reported stressful life event for both Korean War veterans (35%) and comparison group participants (52%). The second most nominated life event category for both groups was personal injury, illness or attack (assessed as not military related) ... 18% of Korean War veterans and 21% of comparison groups participants ... 18% of Korean War veterans nominated a Korean War event and 13% nominated another military event.’ (p. 92)(Sim, Ikin et al. 2005)

Vietnam

Australians served in Vietnam from 1964 to 1972. There are a series of citations reporting PTSD in Vietnam veterans all based on the same random sample of 1,000 Australian Army Vietnam veterans. Data were gathered in an interview and self-report questionnaire booklet between July 1990 and February 1993. The total number of respondent was 641. Of these, 0.8% were 34-39 year age group, 81.3% were aged 40-49, 12.5% 50-59 and 5.3% 60+. (O’Toole, Marshall et al. 1996)

In the initial study PTSD was included under Other Mental Illness, the prevalence of which was 5.3% - 6.0%. The relative risk of veterans developing an Other Mental Illness was five-fold compared to the he Australian population (Table 3). There were differences in prevalence depending on how it was measured but the likelihood of both chronic and current PTSD in Vietnam veterans increased with increasing exposure to combat and war zone trauma (Table 4). When the components of the Combat Index were analysed separately, being a battle casualty had a three-fold impact on the likelihood of developing Vietnam veterans suffering lifetime PTSD and current PTSD (Table 5).

Table 3 Australia: Other mental disorders (including PTSD) in Vietnam Army veterans compared with the age-sex standardized Australian population rates (males)

	Obtained		Response Adjusted	
	Prevalence	RR (99% CI)	Prevalence	RR (95% CI)
Other Mental Illness (a)	5.3%	4.15 (2.37-8.77)	6.0%	4.69 (8.80-6.58)

Source: O'Toole, Marshall, Grayson, Schureck, et al (1996)

Notes:

PTSD included in this category

Table 4 Australia: PTSD in male Vietnam Army veterans by combat and war zone trauma (males)

Measurement Tool	PTSD	21 Item Combat Index (a)			
		1st quartile	2 nd quartile	3 rd quartile	4 th quartile
	Prevalence	OR	OR	OR	OR
Lifetime PTSD					
DIS all cause	17.1%	1.00	2.64	4.43	7.17
DIS combat-related	11.7%	(b)	1.00	1.89	3.70
AUSCID-V Interview	20.9%	1.00	3.03	5.36	9.18
Current PTSD					
AUSCID-V Interview	11.6%	1.00	2.11	6.97	10.33
Mississippi Scale (Cut-off ≥107)	8.1%	1.00	5.6	11.33	25.12

Source: O'Toole, Marshall, Grayson, Schureck, et al (1996)

Notes:

(a) Derived from a self-report 21-item Likert type scale which contains items related to combat and war zone trauma. All t-tests of association between diagnosis and continuous combat score were statistically significant ($p < 0.0005$).

(b) No cases in lowest quartile

Persian Gulf

Australia deployed 1,871 Australian Defence Force personnel to the Gulf region between 2nd August 1990 and 4th September 1991. Gulf War veterans and a group randomly selected from members of the Australian Defence Force (ADF) eligible for, but not deployed to the Gulf War were recruited between August 2000 to April 2002. More than 85% of participating Gulf War veterans and more than 70% of participating comparison group subjects were from the Navy.

Table 5 Australia: PTSD in male Vietnam Army veterans by the components of combat exposure using logistic regression against a binary measure of met vs unmet criteria for PTSD

Combat Index Components	AUSCID-V			
	Lifetime PTSD		Current PTSD	
	OR	95% CI	OR	95% CI
Direct exposure to combat	1.87	1.52-2.29	2.23	1.71-2.90
Exposure to killing and wounding not necessarily in combat	1.77	1.44-2.17	1.51	1.17-1.95
Exposure to civilian mistreatment	1.25	1.14-1.51	1.17	0.93-1.50
Exposure to mutilation	1.21	1.02-1.44	1.29	1.07-1.56
Battle casualty	3.20	1.59-6.45	3.24	1.45-7.25
Disassociation	1.51	1.51-1.36	1.48	1.31-1.68

Source: O'Toole, Marshall, Schureck, Dobson (1999) (O'Toole, Marshall et al. 1999)

Gulf War veterans demonstrated a higher prevalence PTSD. The increase in the likelihood of PTSD in veterans was four-fold using the CIDI and two-fold using the PCL-S – see Table 6. PTSD was most common amongst the lowest ranks in both study groups. Within the Gulf War veterans, levels of Gulf War related stressful experiences were associated with levels of post-Gulf War PTSD. (Occupational and Environmental Health Unit: Monash University 2003)

Table 6 Australia: PTSD in Gulf War veterans (males)

Instrument	Prevalence		Adjusted (a)	
	Veterans	ADF Comparison	OR	95% CI
CIDI: Symptoms present pre Gulf War	1.3% 18/1,381	1.2% 17/1,377	Not recorded	Not recorded
CIDI: Symptoms newly present after the Gulf War (b)	5.4% 73/1,381	1.4% 19/1377	3.9	2.3-6.5
CIDI: Symptoms present 12 mths prior to assessment	5.1% 71/1,381	1.7% 23/1377	4.1	2.4-7.2
PCL-S \geq 50	7.9% 105/1339	4.6% 66/1452	2.0	1.5-2.9

Source: Occupational and Environmental Health Unit: Monash University (2003)

Notes:

(a) Adjusted for service type, rank and age, education and marital status

(b) Age of onset of first symptoms was greater than or equal to the subject's age at 1st August 1990

2 United Kingdom

Persian Gulf and Bosnia

There was a series of published studies which compared three cohorts of UK defence force personnel:

1. Gulf Cohort: UK veterans (excluding special forces personnel) who served in the Persian Gulf region between Sept 1 1990 and June 30 1991 (N=4,248; response rate 70.4%; 92% male)
2. Bosnia Cohort: Stratified (age and rank) sample of defence force personnel deployed to the Bosnia conflict between April 1 1992 and Feb 6 1997 (N=4,250; response rate 61.9%; 91% male).
3. Era Cohort: Stratified (age and rank) sample of defence force personnel serving in the armed forces on Jan 1 1991 who were not deployed to the Gulf War (N=4,246; response rate 62.9%; 93% male)

The initial data was collected using a postal survey beginning in September 1997 and finishing in November 1998. Data analysis was restricted to males. Prevalence was initially measured as posttraumatic stress response (PTSR) and was based on the responses to a 50 symptom checklist. (This measure seems to be unique to this study.) The results indicated that Gulf War veterans had a higher prevalence of PTSR than the other cohorts and there was a two to four-fold likelihood of Gulf veterans experiencing PTSR symptoms in the previous month compared to the other cohorts (Table 7). In sub-samples of the original cohorts it was found that disabled Gulf veterans were not more likely to have experienced PTSR symptoms in the previous month than non-disabled Gulf veterans or disabled Bosnia & Era personnel (Table 8).

Table 7 UK: PTSR in male Gulf War, Bosnian and Era (non-deployed) service personnel

Comparisons	Prevalence	Adjusted (a)		Adjusted – Model 1(b)		Adjusted – Model 2(c)	
		OR	95% CI	OR	95% CI	OR	95% CI
Gulf vs Bosnia(a)	13.2% vs 4.7%			2.6	1.9-3.4	2.3	1.7-3.2
Gulf vs Era (a)	13.2% vs 4.1%			3.8	2.8-4.9	2.7	2.1-3.6
Bosnia vs Era (b)	4.5% vs 4.4%	1.0	0.7-1.3				
Gulf-Bosnia vs Era (b)	13.2% vs 4.5%	2.9	2.1-4.2				

Source: (a) Unwin, Blatchley, Coker, Ferry et al (1999) (b) Hotopf, David, Hull, Ismail et al (2003)

Notes:

(a) Adjusted for age, sex, rank and education

(b) Adjusted for sociodemographic and lifestyle factors

(c) Adjusted for sociodemographic and lifestyle factors plus general health questionnaire score

Table 8 UK: PTSR in sub-samples of Gulf War, Bosnian and Era service personnel (male and female)

Comparisons	Respondents (a)	Unadjusted		Adjusted (b)	
		OR	95% CI	OR	95% CI
Disabled Gulf vs Non-Disabled Gulf (c)	111 vs 96	2.7	0.1-53.9	0.84	0.3-2223.2
Disabled Gulf vs Disabled Bosnian and Era (c)	111 vs 133	0.09	0.1-6.6	1.1	0.1-9.1

Source: Ismail, Kent, Brugha, Hotopf et al (2002)

Notes:

(a) Potential respondents to be included in the sub-samples: 406 Disabled Gulf; 3,407 Non-Disabled Gulf; 416 Disabled Bosnian and Era. The sub-samples excluded those who 'after random selection' had a disease or reported a currently diagnosed serious physical illness.

(b) Adjusted for age, sex, rank and marital status using probability weights

(c) 'Disabled' defined as a score of less than 72.2 on the physical functioning subscale of the SF-36

A follow-up postal survey (conducted in 2001) of a stratified random sample of the Gulf, Bosnian and Era cohorts analysed data for military peacekeepers in the former Yugoslavia (Bosnia and Kosovo), the Arabian Gulf and Cyprus (excluding Northern Ireland and the Gulf War). The analysis indicated that 5.4% were PTSD cases using the PCL-M cut-off of ≥ 45 and, 3.6% ≥ 50 . (Greenberg, Iversen et al. 2008) As shown in Table 9, major difference appears to be that military personnel who were deployed alone with part of another unit were statistically less likely to be a PCL-M case using

a cut-off score of ≥ 50 . In this sample the prevalence of PTSD was higher than the prevalence of PTSD using the PCL-M questionnaire.

Table 9 **UK: PTSD and PTSD by deployment status among military peacekeepers in a stratified sub- sample of the Gulf, Bosnian and Era cohorts (male and female)**

Deployment Status	Respondents (a)	PTSD		PCL-M ≥ 45		PCL-M ≥ 50	
		Count	Percentage	Count	Percentage	Count	Percentage
Complete Unit	661	38	5.7%	36	5.5%	25	3.7%
Part of main unit	428	26	6.1%	21	4.9%	14	3.3%
Part of another unit with colleagues	256	16	6.1%	12	4.8%	9	3.4%
Part of another unit on own	198	10	5.1%	9	4.4%	3	1.4%

Source: Greenberg, Iversen, Hull, Bland, et al (2008)

Notes:

(a) Stratified, randomly selected sub-samples of Gulf, Bosnia and Era cohorts. Included all veterans with a fatigue score of 9, a 50% sample with mid-range fatigue scores of 4-8, and an approximately 1/8th sample with fatigue scores < 4 and all females. No analysis using the fatigue scores is presented.

Iraq

Hotopf et al (2006) compared the health of a random sample of military personnel deployed to the 2003 Iraq war (TELIC 1 N = 4,722, response rate = 62%) with a random sample of non-deployed personnel (Era N = 5,550, response rate = 56%). The focus was on Operation TELIC 1, which involved the 'build up and completion of major combat operations' from 18th January to 28th June in 2003. Data were collected on a questionnaire by either mail or personal visit between June 2004 and 2nd March 2006. Seventeen percent (17%) of respondents were under 25 years of age, 19% were aged 25-29 years, 41% 30-39 years, 19% 40-49 years and 4% were aged 50 and over. Ninety percent (90%) of the respondents were male. As shown in Table 7 the deployment history of both groups was complex and there were differences between the two groups.(Hotopf, Hull et al. 2006).

PTSD data were collected using the PCL with a cut-off score ≥ 50 indicative of caseness. As shown in Table 8, the only statistically significant differences between the groups studied were between the veterans who had experienced combat duties (prevalence 6%) and veterans who had not (prevalence 3%).

Table 10 UK: Previous deployments of TELIC 1 and non-TELIC 1 respondents

Deployment	Period	Era		TELIC 1		P
		Number	Percent	Number	Percent	Value*
Northern Iraq/Turkey	1991–2003	196	4%	229	5%	0.0001
Falklands war	1982	238	5%	116	3%	<0.0001
Sierra Leone	2000	259	5%	250	6%	0.1
Afghanistan	2001–present	414	8%	666	15%	<0.0001
Oman (Saif Sareea)	2002	402	8%	703	16%	<0.0001
Gulf war	1990–91	684	13%	662	15%	0.02
Kosovo	1999–present	912	17%	1,018	23%	<0.0001
Bosnia Herzegovina	1992–present	1,459	28%	1,231	27%	0.6
Northern Ireland	1969–present	1,758	33%	1,245	28%	<0.0001
No previous deployment		1,098	31%	1,606	31%	0.5

Source: Hotopf, Hull, Fear, Browne, et al (2006)

Notes:

* Pearson's χ^2 test with Rao and Scott second order correction. Table shows ten comparisons. Using the Bonferroni correction, the threshold for statistical significance would be adjusted to 0.005

† Excluding TELIC 1 and Saif Sareea

Table 11 UK: PTSD in Navy/Marines, Army and Air Force personnel 1-3 years after deployment to Iraq (males and females)

	PLC \geq 50 Cases		Adjusted	
	Percentage	Number	OR	95% CI
Era	4%	135/3,698		
Iraq War	4%	191/4,825	1.00 (a)	0.79-1.28
Reservists				
Era	4%	193/4,546		
TELIC 1	4%	201/4,613	1.20 (b)	0.95-1.50
Regulars				
Era	3%	171/4,676		
TELIC 1	4%	155/3,487	1.17 (c)	0.92-1.48

Regulars deployed to Iraq War Only: Time Since End of Last TELIC Deployment				
0-5 months	2%	13/453	1.00 (d)	
6-11 months	4%	17/422	1.53 (d)	0.67-3.46
12-17 months	3%	40/1,269	1.20 (d)	0.55-2.63
18-23 months	4%	19/490	1.73 (d)	0.74-4.04
\geq 24 months	4%	61/1,752	1.68 (d)	0.78-3.63
Combat Duties				
Non-Combat Duties	3%	97/3,125		
Combat Duties	6%	70/1,238	1.49 (e)	1.05-2.13

Source: Hotopf, Hull, Fear, Browne, et al (2006)

Notes:

(a) Adjusted for age, sex, rank, education and marital status, service branch, and fitness to deploy

(b) Adjusted for age, sex, rank, educational and marital status, service branch, fitness to deploy and reservists and take account of sampling weights

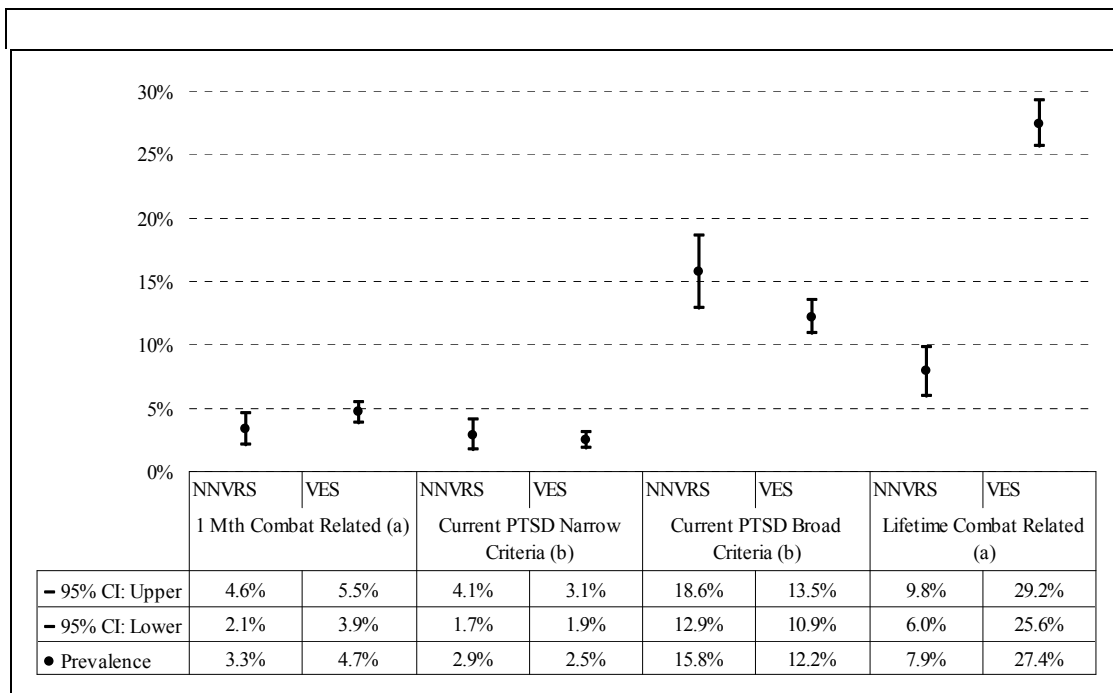
- (c) Adjusted for age, sex, rank, educational and marital status, service branch, and fitness to deploy
- (d) Adjusted for age, sex, rank, educational and marital status, service branch, fitness to deploy and most recent TELIC deployment
- (e) Adjusted for age, sex, rank, educational and marital status, service branch and fitness to deploy.

3 United States

Vietnam

There were two large studies of US Vietnam Veterans: the National Veterans Readjustment Study (NVVRS) and the Vietnam Experience Study (VES). Thompson, Gottesman and Zalewski (2006) attempted to reconcile the results from each using comparable PTSD criteria across both studies. As can be seen from the results in Figure 1 (expressed in both graphical and tabular form), the one-month combat related and the current PTSD using the narrow criteria are similar for both studies. However, the study failed to reconcile the lifetime combat related PTSD for both groups.

Figure 1 USA: PTSD among Vietnam veterans 10 years after withdrawal of troops from Vietnam (males)



Source: Thompson, Gottesman, Zalewski (2006)

Notes

(a) Based in the DIS but modified to include 21 symptom probes

(b) Based on the DSM-III-R definition for the DIS instrument

Iraq and Afghanistan

There is a large amount of literature relating to PTSD in defence force personnel who have returned from deployment in Iraq and Afghanistan (Table 14). It is quite difficult to discern patterns in these data. However, the most surprising results are for the Smith et al (2008) study which appears to show major differences between sub-groups

based on the presence of PTSD prior to deployment. This study, which is the most recent, is examined in more detail.

This is a study of a population based US military cohort of active military and Reserve/National Guard personnel who had deployments in Iraq and Afghanistan. Results were presented for respondents who:

1. Had not been deployed prior to, or were not on deployment when, their baseline questionnaire was being completed (July 2001-June 2003); and
2. Were not on deployment when their follow-up questionnaire was completed (June 2004 and February 2006).

The mean elapsed time between submission of the baseline and follow-up questionnaires was 2.7 years (SD 0.5; median 2.8).

The PCL-S was used with ‘sensitive’ and ‘specific’ criteria to determine the presence of symptoms or a diagnosis of PTSD. The sensitive criteria was the symptom cluster method and the specific criteria included both the symptom cluster method and a score of ≥ 50 . At baseline and follow-up participants were also asked whether or not their doctor or other health professional had ever told them that they had post-traumatic stress disorder. The cohort was then divided into the four groups based on whether or not they had symptoms or diagnosis at baseline and/or follow-up (Table 9)

Table 12 Sub-groups for analysis of new onset and persisting PTSD

	Baseline: No PTSD	Baseline: PTSD
Follow-up: No PTSD	Group 1: No PTSD	Group 2: No Persisting PTSD
Follow-up: PTSD	Group 3: New Onset	Group 4: Persisting PTSD

For the New Onset group (Group 3 in Table 12), the prevalence of PTSD was highest in those who had combat exposure while on deployment. For the Persisting PTSD group, prevalence was lowest in those who were deployed with no combat exposure (Table 13).

Table 13 USA: PTSD in Army, Air Force, Navy/Coast guard and Marines by deployment status (males and females)

Deployment Status	New Onset Symptoms (Group 3)				Persisting Symptoms (Group 4)			
	Specific Criteria (a)		Sensitive Criteria (b)		Specific Criteria (a)		Sensitive Criteria (b)	
Not deployed	849	2.3%	1,106	3.0%	391	45.9%	614	47.6%
Deployed: no combat	89	1.4%	128	2.1%	17	26.2%	30	22.4%
Deployed: combat	409	7.6%	461	8.7%	47	43.5%	89	47.9%
Overall	1,347/48,447 (2.8%)		1,695/47,837 (3.5%)		455/995 (45.7%)		733/1,659 (44.2%)	

Source: Smith, Ryan, Wingard, Slyment, et al (2008)

Notes:

(a) Specific Criteria: Symptom Cluster Method of scoring and PCL ≥ 50

(b) Sensitive Criteria: PCL ≥ 50 only

Table 14 USA: Summary of studies of PTSD prevalence pre and post deployment

				Outcome Measures				Medical Records
				PCL - SCM	PCL ≥ 50	PC-PTSD	SPT SS	ICD-9-CM
Sensitivity of Outcome Measures				1.00	0.60	0.91	0.94	
Specificity of Outcome Measures				0.92	0.99	0.72	0.60	
	Service and deployment status	Recruitment Period	Deployment Arena					
Assessment pre-deployment								
Hoge, Castro, Messer, McGurk, et al (2004)(Hoge, Castro et al. 2004)	Army: one week pre deployment		Iraq	9.4%	5.0%			
Assessment post-deployment								
Hoge, Auchterlonie, Milliken (2006)(Hoge, Auchterlonie et al. 2006)	Army and Marine	1 May 2003 - April 30 2004	Afghanistan	9.8%				
Hoge, Auchterlonie, Milliken (2006)(Hoge, Auchterlonie et al. 2006)	Army and Marine	1 May 2003 - April 30 2004	Iraq	4.7%				
Hoge, Auchterlonie, Milliken (2006)(Hoge, Auchterlonie et al. 2006)	Army and Marine	1 May 2003 - April 30 2004	Other Places	2.1%				
Vasterling, Proctor, Moroso, Kane, et al (2006)(Vasterling, Proctor et al. 2006)	Army		Iraq		11.6%			
Kolkow, Spira, Morse, Grieger (2007)(Kolkow, Spira et al. 2007)	Health care providers		Iraq and Afghanistan		9.0%			
Martin (2007)(Martin 2007)	Armed forces	2005	Iraq			10.5%		
Milliken, Auchterlonie, Hoge (2007)(Milliken, Auchterlonie et al. 2007)	Army Reserve	1 June 2005 - 31 Dec 2006	Iraq			12.7%		
Milliken, Auchterlonie, Hoge (2007)(Milliken, Auchterlonie et al. 2007)	Army Active	1 June 2005 - 31 Dec 2006	Iraq			11.8%		
Lapierre, Schwegler, LaBauve (2007)(Lapierre, Schwegler et al. 2007)	Army	Feb - Jul 2005	Iraq				31%	
Lapierre, Schwegler, LaBauve (2007)(Lapierre, Schwegler et al. 2007)	Army	Feb - Jul 2006	Afghanistan				30%	
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces with combat: no baseline PTSD		Iraq and Afghanistan	8.7%	7.3%			

				Outcome Measures				Medical Records
				PCL - SCM	PCL ≥ 50	PC-PTSD	SPT SS	ICD-9-CM
Sensitivity of Outcome Measures				1.00	0.60	0.91	0.94	
Specificity of Outcome Measures				0.92	0.99	0.72	0.60	
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces w/out combat: no baseline symptoms/diagnosis PTSD		Iraq and Afghanistan	2.1%	1.4%			
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces not deployed: no baseline PTSD		Iraq and Afghanistan	3.0%	2.3%			
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces with combat: baseline PTSD		Iraq and Afghanistan	47.9%	43.5%			
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces w/out combat: baseline PTSD		Iraq and Afghanistan	22.4%	26.2%			
Smith, Ryan, Wingard, Slyment, et al (2008)(Smith, Ryan et al. 2008)	Armed forces not deployed: baseline PTSD		Iraq and Afghanistan	45.9%	47.6%			
Assessment 3-6 months post-deployment								
Hoge, Castro, Messer, McGurk, et al (2004)(Hoge, Castro et al. 2004)	Army: 3-4 months post deployment		Iraq	18.0%	12.9%			
Hoge, Castro, Messer, McGurk, et al (2004)(Hoge, Castro et al. 2004)	Marine: 3-4 months post deployment		Iraq	19.9%	12.2%			
Hoge, Castro, Messer, McGurk, et al (2004)(Hoge, Castro et al. 2004)	Army: 3-4 months post deployment		Afghanistan	11.5%	6.2%			
Milliken, Auchterlonie, Hoge (2007)(Milliken, Auchterlonie et al. 2007)	Army Reserve: 3-6 months deployment	1 June 2005 - 31 Dec 2006	Iraq			24.5%		
Milliken, Auchterlonie, Hoge (2007)(Milliken, Auchterlonie et al. 2007)	Army Active: 3-6 months post deployment	1 June 2005 - 31 Dec 2006	Iraq			16.7%		
Assessment 1 year post deployment								
Hoge, Terhakoplan, Castro, Messer, et al (2007)(Hoge, Terhakopian et al. 2007)	Army: 1 year post deployment		Iraq		16.6%			
Wounded/Receiving Care								
Grieger, Cozza, Ursano, Hoge, et al (2006)(Grieger, Cozza et al. 2006)	Soldiers wounded in combat and evacuated: assessment 1	Mar 2003 - Sept 2004			4.2%			

				Outcome Measures				Medical Records
				PCL - SCM	PCL \geq 50	PC-PTSD	SPT SS	ICD-9-CM
Sensitivity of Outcome Measures				1.00	0.60	0.91	0.94	
Specificity of Outcome Measures				0.92	0.99	0.72	0.60	
	month							
Grieger, Cozza, Ursano, Hoge, et al (2006)(Grieger, Cozza et al. 2006)	Soldiers wounded in combat and evacuated: assessment 4 months	Mar 2003 - Sept 2004			12.2%			
Grieger, Cozza, Ursano, Hoge, et al (2006)(Grieger, Cozza et al. 2006)	Soldiers wounded in combat and evacuated: assessment 7 months	Mar 2003 - Sept 2004			12.0%			
Seal, Bertenthal, Miner, Sen, et al (2007)(Seal, Bertenthal et al. 2007)	Veterans receiving care	30 Sept 2001 - 30 Sept 2005	Iraq and Afghanistan					13.0%
Erbes, Westermeyer, Engdahi, Johnson (2007)(Erbes, Westermeyer et al. 2007)	Veterans receiving care: excl those receiving mental health services	February 2005 - time of publication	Iraq and Afghanistan		12.0%			

Source: Ramchand, Karney, Osilla, Burns, et al (2008: 60-81)

Summary

Summarizing the results of these studies in a meaningful way is extremely difficult. In part this is due to the methodological differences (e.g., timing and method of measuring PTSD), and individual differences as well as differences in pre and post deployment experiences. These differences have led to differences in prevalence rates both within and between countries. However, there are some broad trends that can be observed.

There appears to be a background or base level of PTSD in all the populations studied – military and civilian. Based on the PCL-S with a cut-off score of ≥ 50 these levels appear to be approximately 4% to 5% (Tables 2, 5 and 8).

The prevalence of PTSD in deployed veterans varies across countries and across the conflicts to which military personnel are deployed. This is best demonstrated by presenting prevalence rates in which the same measurement tool has been used (Table 15)

Table 15 Prevalence in veteran populations using PCL with cut-off score ≥ 50

	UK (a)	Australia (b)	USA (c)
Korean		25.6%	
Persian Gulf		7.9%	
Iraq	4%		12.2%-16.6%
Afghanistan			6.2%
Afghanistan & Iraq			9.0%

Sources: (a) Table 10, (b) Table 2, Table 6 (c) Table 14

- Deployment does not necessarily increase the prevalence of this background level of PTSD. For example:
 - (a) In one prospective study of US military personnel, deployment decreased the prevalence of PTSD in the group assessed as having PTSD prior to deployment (Table 13).
 - (b) In a study of UK military personnel deployment to Bosnia and did not increase the prevalence of PTSD compared to the control group (Table 10).
- However, combat exposure while on deployment generally increases the likelihood of PTSD (Table 4, Table 5,, Table 10, Table 13). Only in the US prospective study did it decrease the prevalence of PTSD (Table 13).
- Length of time since deployment may affect the results as Ramchand, Karney, Osilla, Burns, et al (2008) state but it is difficult to discern this pattern in all the data presented.

Australian Data

Data were available for Korean, Vietnam and Persian Gulf veterans. Time from deployment to measurement of PTSD varied as did the method of identifying the prevalence of PTSD. PTSD prevalence was highest for the Korean veterans and

lowest for the Persian Gulf veterans which would appear to support the conclusion that time since deployment could affect the results of the studies. Diagnostic

Table 16 Australia: summary of PTSD prevalence data for veteran populations

Conflict	Recruitment	Age of Participants	Participation Rate	Prevalence	
Korea 1950-56	2004	65+	N = 5,564 91%	PCL \geq 50	25.6%
Vietnam 1964-72	1990-91	17% <25 40% 25-34 39 % 35-49 4 % \geq 50	N = 641 64%	Diagnostic Interviews: Lifetime PTSD (a) Current PTSD (b) Mississippi Scale \geq 107 Current	11.7%-20.9% 11.6% 8.1%
Persian Gulf 1990-91	2000-2001	12% < 30 29% 30-34 48% \geq 35-44 15% \geq 45	N=1,381 76%	Diagnostic Interviews: Symptoms newly present after Gulf War (c) Symptoms present in previous 12 months (c) PCL-S \geq 50	5.4% 5.1% 7.9%

Notes:(a) DIS and AUSCID-V; (b) AUSCID-V; (c) CIDI

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Appendix 5 Barriers to mental health care in the veteran community

The following is an overview of Australian and International research on mental health in serving military members and barriers to care. Studies include those conducted in the US, Canada, Britain, and Australia, and predominantly focus on barriers to seeking mental health treatment and support in the veteran communities of these countries.

Australian Research

Hawthorne and Hayles et al (2004) investigated patterns of (pathways to) mental health care for veterans recently compensated for a mental health condition. The researchers were chiefly concerned with identifying the 'what' and 'how' of access issues, as well as identifying barriers. 669 vets from WWII, Vietnam and other Peacekeeping regions who had been compensated were sent mail questionnaires and were then interviewed by telephone over a six-month period. 30% reported they were not seeking treatment for their mental health problems. Barriers systemic to those not seeking treatment included poor knowledge or uncertainty of what services were available, and/or who should be contacted, geographical barriers, and limits on the types of care available. Perception barriers included that no treatment was necessary, while others were self-treating. Under a quarter of veterans' long-term treatment plan precluded care under the study period.

Additionally, 23% of veterans ceased treatment for their compensation condition, a quarter of these cited treatment failure, while 19% ceased for reasons of treatment success. A further 15% stopped treatment due to a lack of access to appropriate health services, and 7% referred to organisational difficulties with the DVA, VVCS or ADF. The groups most likely to stop treatment were younger veterans from lower SES quartiles and those who reported treatment failure.

Barriers were most frequently reported by Peacekeepers (12%), followed by Vietnam (9%), and WWII veterans (4%). Accepting that there was a health problem in the first place proved to be a common barrier to accessing health care. Mental health literacy was a common problem and veterans with three or more conditions, PTSD sufferers, poorer veterans, and younger veterans were the most affected by literacy problems. Veterans with PTSD were more likely to report mistrust or disappointment with health care. This was also the case for veterans living in remote areas. Mistrust referred to dissatisfaction with the information provided by the DVA, specifically perceptions that staff did not possess the requisite knowledge. There was a common perception that DVA staff were in the practice of withholding information until it was specifically requested. Veterans also reported difficulties in navigating the compensation system as contributing towards a general distrust of the DVA and the quality of care it provided.

The findings also suggest that mental health services were seldom used independently of other medical services, 44% of the veterans did not seek help solely for a mental health condition. Veterans accessed mental health care primarily through a GP in 43%

of cases. This is consistent with the finding that mental health conditions were mostly revealed when the veteran sought treatment for a physical condition. Pathways to receiving health care services were very short with few exceeding more than three services (two being the norm).

The research also revealed that a more informal network made up of allied health practitioners (AHPs), ESOs and friends, and the Internet or other media were heavily relied on as sources of assistance. This informal network was considered to be of crucial importance in veterans' accessing services and support for their conditions. Moreover, the researchers speculated that the limited use of VVCS could be attributed to its title which was misleading. The lack of GP referral was also a significant factor.

Australian Cases

A short article in *The Age* (McKenzie, 2008), describes the successful compensation claims for family members (siblings and parents who were not dependents), of deceased servicemen. The author focused on four cases of bullying which resulted in suicide. This led to an inquiry into bullying and mistreatment of officers who had mental health problems. The author suggests a barrier to seeking treatment resided in the incidences of bullying and the mental health affects of such practices.

International Research

In an American review McFee (2008) discusses the challenges faced by Persian Gulf troops and the provision of improved civilian health care and subsequent re-entry of ex-service personnel into society. The author argues that the lessons from the first Gulf War, suggests a complex of factors needs to be considered when dealing with and treating returning soldiers. Amongst the reasons which accounted for a lack in seeking health care were combat-related injuries such as blast injuries and TBI (traumatic brain injury), which were difficult to diagnose and symptoms could be easily confused with, or lost to, other disorders such as PTSD. Moreover, the effects could occur from two up to 10 or more years after the injury. Pride also was a significant factor in preventing members from seeking help (even for physical injuries).

The study revealed were high reporting rates for women suffering PTSD as a result of a sexual assault. There was also a significant representation of ex-service personnel (26%) who accounted for the homeless population.

Keuhn (2008) reports on a study in the US which found a significant number, about half, of persons with PTSD remained undiagnosed and thus untreated. This was due in part to stigma associated with having a mental health problem, as well as a lack of resources (mental health specialists). Given veterans accessed primary care frequently, this suggests there was a problem in primary care specialists who were unable to detect symptoms of PTSD. A barrier to care therefore was that doctors were not recognising the symptoms of PTSD. The DoD had responded to this by mandating that VA primary care providers commence screening for PTSD and provided a screening tool for this purpose.

A British study (Iversen, Dyson et al., 2005) examined help seeking behaviours and treatment experiences of ex-service personnel. Using a telephone survey of 496 ex-

service personnel from the Persian Gulf War, Bosnia and non-deployed group (who had previously participated in a cohort study), the investigators reviewed the mental health needs and treatment experiences of the 'most vulnerable' of ex-service personnel. The findings revealed that those with a psychiatric diagnosis were of a lower rank and either divorced or separated. 28.9% reported having a mental health problem during service, and the most common problems were depression (48.3%), then stress (37.9%). Half of those who experienced mental health problems in service reported seeking help. Stigma and embarrassment were cited as the most common reasons for not seeking help.

The study also found classic psychiatric disorders rather than service-related psychiatric injury predominated, and access to a psychiatrist was more likely to occur when the individual was still in service rather than later (56.5% and 28.7% respectively). This figure was most likely due to the free provision of health services whilst in the military. 58.4% of the veterans were currently seeking help, 86.9% of those from their GP. For those not seeking help, 72% cited 'I could deal with it myself' as a reason, while 20% reported perceived stigma and embarrassment. The authors suggest this indicates two key barriers, a military culture which promotes stoicism, resilience and courage, and fears around stigma or embarrassment in admitting a need for help.

The researchers acknowledge that due to sample attrition and the characteristics of the sample, the real picture regarding mental health problems in ex-servicemen was likely to be worse than the data indicated. They also conceded that the 'most vulnerable' members of this group (the homeless) were excluded from the study.

Richardson and Elhai et al (2006) surveyed 1016 Canadian veterans from the Canadian armed forces to investigate the relationship between medical use and PTSD. The research found veterans with PTSD were 16.4 times more likely to use a medical service than veterans without the condition. The findings indicated that screening for PTSD was important in primary care settings especially in patients with a history of military service.

In a UK study van Staden and Fear et al (2007) examined the factors associated with poor outcomes in the discharge and transition of members of a high risk population; members discharged from a Military Corrective Training Centre. They charted the health seeking paths of 74 young British veterans transitioning out of the military. Participants were interviewed one week prior to discharge (n=111) and followed up six months later (n=74). The results showed that 56% were categorised as being highly disadvantaged in the follow up to their discharge. 82% were affected by mental health problems before discharge, and 53% six months after discharge. The factors associated with being disadvantaged were having a mental health problem at discharge, having no permanent accommodation to return to, receiving an administrative discharge and having a shorter sentence period. These were considered risk factors in poor outcomes on leaving the military. Only a small percent of individuals with mental health problems were seeking help, most preferred to use the informal networks of support such as friends and family instead.

Using data from 2001 National Survey of Veterans (NSV), Elhai and Grubaugh et al (2008) examine predictive factors such as need, over socioeconomic and access

factors when it came to using VA mental health care services in the United States. They examine differences between VA and non VA mental health treatment utilisation. Previously, small sample sizes and the limited scope of studies on barriers to accessing treatment for mental health problems inadequately accounted for large-scale research on veterans from diverse war eras. To overcome this problem, they drew data (20,048 participants) from the NSV to examine the intensity of mental healthcare visits among veterans and what factors influenced utilisation. They analysed the data according to three types of variables; 'predisposition' which refers to socio-demographic factors such as gender and age, 'enabling' which refers to resource and access considerations such as being in possession of medical insurance or not, and 'need' which relates to illness.

Their analysis revealed that physical health functioning and disability were key predictors of mental health care utilisation among veterans and that these were not overshadowed by predisposing and enabling variables. This, they argue, highlights the importance of need and illness in understanding mental health care use in veterans. They also found that young veterans, who are ill and lacking in resources, are more likely to rely on VA services.

Conclusion and General Observations

The literature consistently reveals that barriers to care are more widespread in veterans who had mental health problems either during or after service. These barriers chiefly referred to veterans' perceptions of their own predicament and self-management approaches which was attributed to perceived 'uselessness' of available treatments. There were also barriers around knowledge of what services were available and how this information was disseminated.

As the literature on serving members, the research in this review reveals that only a minority of individuals with mental health problems appear to be seeking help. In addition to access, health literacy and perceptions of treatment efficacy, the findings point to stigma being a determining factor.

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Appendix 6 Rapid literature review of mental health promotion programs

Mental health promotion programs

In a guest editorial, Jane-Llopis (2006) reported that a number of literature reviews have demonstrated that prevention of mental disorders and promotion of mental health can be effective. This could occur across the lifespan, although most related to children and adolescents. Topic-specific literature overviews have confirmed that prevention and promotion approaches have worked for areas such as violence and aggression, depression and substance use. To date, meta-analyses have been specific to particular topics and age groups. The only program relevant to this review subjected to a meta-analysis is for the prevention of depressive symptoms.

Workplace mental health promotion programs have been effective. Legislation and environmental interventions have led to increases in mental health and wellbeing as well as reductions in symptoms of anxiety, depression, and stress-related problems. They can also lead to increased productivity and reductions of sick leave.

Very few cost benefit and cost effectiveness studies have been attempted to quantify the economic impact of mental health promotion programmes.

Herrman (2005) also concluded that mental health promotion programs can contribute to better mental health and well-being of the population. Employing public health principles, they add value across the lifespan and in settings such as perinatal care, schools, workplaces and local communities. There is also growing evidence is available that mental health promotion also generates a variety of social and economic benefits. Evidence though remains rather limited and is frequently based on only one or two well-designed outcome studies, mostly in developed countries. Knowledge of the robustness of findings across sites and their sensitivity to cultural and economical circumstances is still meagre. Not all mental health promotion programs are effective or have been evaluated.

Mental health literacy programs

Jorm (2000) reported that findings from a German study where people were much more reluctant to discuss mental disorders with friends and relatives than physical health problems. In the US people were reluctant to seek treatment for depression fearing a negative impact on their employment circumstances. In the UK the majority of people would feel embarrassed discussing depression with their GP because they feared being seen as neurotic or unbalanced. In India patients often presented their mental distress in physical terms.

Bourget and Chenier (2007) reported on levels of mental health literacy in Canada. This covered perceived prevalence and recognition of mental disorders, perceived causes, attitudes about treatment and recovery, conceptions of mental illness, stigma and perceptions of dangerousness, beliefs about protecting/promoting mental health and perceived linkages between mental and physical health.

Canadians appeared to have reasonably good mental health literacy regarding prevalence of mental disorders and their recognition. They preferred psychosocial explanations for mental health problems, less so for serious mental illness where they preferred biomedical explanations. They were inclined to recommend medical help for symptoms of mental disorders though remaining somewhat ambivalent about it. This was true for common mental health problems and with regard to psychiatric medications. Stigma and discrimination toward persons with mental disorders remained a problem in Canada, more so for serious mental illness. They knew of the existence of stigma and discrimination towards mental disorders and were reluctant to disclose mental health problems especially at work for fear of stigma and discrimination. They appeared to have good knowledge of prevention strategies.

Francis et al (2002) concluded that there was evidence that mass media campaigns designed to reach the general public can achieve positive outcomes in terms of mental health literacy. Campaigns were particularly effective when they involved more than one form of media, and included community-based components and/or direct interventions. It was, however, important to note that the impact of such campaigns is limited. Mental health literacy programs that targeted the general public but did not involve mass media approaches appeared to be less common, but showed some evidence of effectiveness in terms of attitude change. Importantly, studies of such programs have found that direct contact with individuals with mental illness is associated with the development of more positive attitudes.

It was clearly important to bear in mind the theoretical basis for communication strategies. Most of the programs studied were conducted in countries other than Australia and their impact in an Australian setting remains unclear. In addition, significant methodological issues emerged in a number of studies. The cost-effectiveness of programs has not been addressed. Much of the previous research has focused only on evaluation of outcomes, and neglected evaluation of the development and implementation phases of communication and information programs.

Summary

Stigma and discrimination toward persons with mental disorders remains a problem in many countries more so for serious mental illness. There is evidence that both mental health promotion and mental health literacy programs can be effective and make a contribution to both the mental health and wellbeing of the community. This includes campaigns in occupational settings. The evidence base though is still limited. The effects of mental literacy campaigns may be limited.

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Appendix 7 Rapid literature review of interventions to reduce alcohol misuse

Introduction

This scoping of the literature on interventions to reduce alcohol misuse has been structured, in the first instance, according to whether the target group for the interventions was the civilian population (civilian studies) or military personnel (military studies). The civilian studies include four systematic reviews of brief interventions for people misusing alcohol.(Trent 1998; Foxcroft, Ireland et al. 2002; Kaner, Dickinson et al. 2007) The military studies include two evaluations undertaken by Turning Point for the Australian Defence Force,(Berends, Roberts et al. 2005; Roberts 2007) six outcome studies of interventions undertaken with military populations in the U.S.(Westhuis, Levine et al. 1994; Stagliano, Richards et al. 1995; Trent 1998; Westhuis, Hayashi et al. 1998; Hurtado, Shaffer et al. 2003; Storer 2003) and two U.S. implementation studies (Fernandez, Hartman et al. 2006; Simon-Arndt, Hurtado et al. 2006).

Civilian Studies

All Ages

The civilian studies included three systematic reviews and meta-analyses of trials of brief alcohol interventions (BAI) for adults aged 15 years. They span a decade; the first was published in 1997 and the third in 2007. The settings for the trials included in the reviews are mainly primary care (outpatients and clinics). The target groups are people with alcohol misuse problems who are not alcohol dependent and who do not have a major psychiatric disorder. They generally involved people attending the health care settings for non-alcohol related problems. The main outcome measure for the three meta-analyses was changes in level of alcohol consumption.

Wilk et al (1997) concluded that heavy drinkers receiving the BAI were twice as likely to have reduced their alcohol intake six to twelve months later than those who did not.(Wilk, Jensen et al. 1997) However, methodological difficulties with the studies mean that the benefit from the intervention may be lower than stated. The authors of the 2005 meta-analysis concluded that BAI aimed at reducing alcohol consumption is effective in primary care setting and the effect can last for two years. They noted that the successful BAI typically involved 15 minutes consultations, patients were also given written material and were offered an opportunity for a follow-up consultation.(Bertholet, Daepfen et al. 2005) However, only half the RCT with an alcohol consumption outcome measure reported a positive effect. It seems, therefore that the authors' conclusion may be optimistic. In 2007, Kaner et al concluded BAI was successful in reducing male primary care patients but not female patients. (Kaner, Dickinson et al. 2007) In the studies included in this meta-analysis there were differential dropout rates between the control and intervention arms which may mean the benefits are not quite as high as stated.

In all three reviews participants in the control arms also reduced their alcohol consumption. According to Kaner et al (2007) the reasons for this are unclear but it may be that screening alone may be an impetus for change for some people.(Kaner, Dickinson et al. 2007)

Young People

The final civilian study was a review of BAI designed to reduce alcohol misuse in young people (<25 years of age) and a re-analysis on an intention-to-treat basis of three apparently effective long-term studies. The authors concluded that the short-term studies (<1 year follow-up) provided no clear evidence of effectiveness and the three medium-term studies (1-3 years follow-up) were 'potentially' effective. However, two had severe methodological shortcomings and one had very small effect sizes. The conclusions for the long-term studies (>3 years follow-up) indicated that one was most 'valuable' and the culturally focussed intervention 'showed promise'.(Foxcroft, Ireland et al. 2002) However, the results of the intention-to-treat analysis for the long-term interventions do not support the conclusions.

Military Studies

Australian Defence Force Evaluations

The most recent Australian Defence Force (ADF) evaluation was of the Alcohol, Tobacco and Other Drugs Services (ATODS) Program. This is a tri-service, centrally based model of service delivery which came into existence in 2002. This new model of service delivery has met with some resistance but over time communication has improved and positive working relationships have been established. Information collected in interviews with key informants and a survey of military personnel and civilians receiving training from ATODS staff (response rate 31%) indicated that the principles under-pinning the model are supported but that they may require some modification to allow for the military environment. ATODS was regarded as 'effective' in terms of meeting its objectives there was no information about the program's impact on people with alcohol, tobacco and other drug problems. A particular strength of the model is the education and training component that has increased military personnel's capacity to respond to ATOD concerns. However, there is some concern that the train the trainer model may not be appropriate to the ADF because of time constraints for the trainers to conduct training. Challenges to the sustainability of the ATODS are the paucity of staff resources, funding uncertainty and lack of command support. One of the changes introduced by ATODS was the introduction of the Alcohol Use Disorders Identification Test (AUDIT) - a brief screening instrument for excessive alcohol use, but it is not clear how often or when this is used.

The second evaluation was of the group counselling component of the Alcohol and Rehabilitation and Education Program (AREP). Group counselling is provided as part of a four week 'closed' residential treatment program for people with alcohol problems. Other elements in this residential program include life skills workshops, physical and team building activities, individual counselling, relapse prevention and alcohol and other drug (AOD) education, and an introduction to self-help groups. The evaluation of the group counselling component was unable to comment on the

effectiveness of group counselling because the follow-up data had not been analysed. The author's key finding was that the AREP group counselling was consistent with 'best practice' and recommended that AREP's progress towards meeting or exceeding the standards for evidence based practice in group counselling be acknowledged.(Roberts 2007)

U.S. Outcome Studies

Four of the outcome studies were for substance abuse (Westhuis, Levine et al. 1994; Stagliano, Richards et al. 1995; Westhuis, Hayashi et al. 1998; Storer 2003) and two were alcohol specific.(Trent 1998; Hurtado, Shaffer et al. 2003)

Substance Abuse

Three of the substance abuse citations related to the U.S. Army's Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) in the 1990s. These studies indicated that outpatient enrollees were significantly different from inpatient enrollees in terms of age, rank, severity, substance being abused and referral pathway. In mixed gender interventions women had better outcomes than men. The education and awareness component when combined with individual and group therapy resulted in better outcomes than education and awareness alone. Soldiers with substance abuse issues who are deployed to a war zone have special needs and the program was viewed as not doing enough for this group.(Westhuis, Levine et al. 1994; Stagliano, Richards et al. 1995; Westhuis, Hayashi et al. 1998)

The fourth substance abuse study involved a retrospective analysis of outcome data for a brief intervention with inpatients at the Naval Medical Center in Portsmouth in the U.S in 2000-2001. The simple descriptive data analyses indicated that the brief intervention was not effective and the author proposes a number of reasons for this.(Storer 2003) The conclusions would have had more weight if regression analysis has been used to control for the confounding variables. The study raises more questions than it answers with regard to the effectiveness of the intervention.

Alcohol Specific

Both the alcohol abuse studies were with Naval personnel. One citation examined the effect of shortening the length of residential treatment from six to four weeks. This program has also had an extended community care component that enrollees could access once they left residential care. The data analyses indicated that the length of participation in the community care was the most important predictor of treatment and shortening the length of residential component would not adversely affect outcomes.(Trent 1998) However, loss to follow up was high (60%) and it is far from clear how this was handled in the analysis. Therefore the results need to be treated with some caution.

The second study evaluated the effect of a brief intervention before participants were deployed to Japan. The data indicated that the brief intervention had a positive impact on only a small number of the outcome measures. The authors concluded that the program may have resulted in some short-term reduction in alcohol consumption but it did not have any effect in the longer term on drinking behaviour. Loss to follow-up

in the intervention group was also high (76%) and the presence of a number of important confounders mean that even a tentative conclusion of effectiveness needs to be treated with caution.

U.S. Implementation Studies

One of the implementation studies involved an assessment of the usefulness of a web-based brief alcohol intervention (BAI). It consisted of assessing users' satisfaction with the web-based BAI. The authors concluded that, despite the limitations of the study, a web-based assessment and feedback program is a 'promising mechanism' for providing a BAI.(Simon-Arndt, Hurtado et al. 2006) However, the methodological shortcomings and the failure to use the training as intended do not support the authors' optimistic conclusions.

The second implementation study was a description of a BAI adapted from a civilian trial that could be used in a military treatment facility. The author indicates that a number of recent systematic reviews have shown brief interventions to be successful in reducing harmful levels of alcohol use in medical care settings.

Conclusions

The literature relating to brief alcohol interventions (BAI) in primary care setting for people who misuse alcohol, but who are not alcohol dependent, indicate that brief interventions, and even screening without a BAI, have the potential to reduce alcohol misuse. Methodological shortcomings with the studies mean that the effects of the interventions produced in the reviews are optimistic and it is clear that not all BAI are effective. Research into what distinguishes and effective BAI from an ineffective one is not well developed.

It cannot be assumed that the impact of civilian interventions will automatically generalize to military populations or to those suffering from alcohol dependence. Methodological shortcomings in the American military outcome studies mean that authors' conclusions as to effectiveness and the reasons advanced for the apparent lack of effectiveness need to be treated with extreme caution. There is nothing to suggest that a web-based intervention would be successful in reducing alcohol consumption military populations.

Bearing these caveats in mind, this scoping review leads to the following hypotheses: (i) regular screening without any other intervention has the potential to reduce the level of alcohol misuse; (ii) BAI has the potential to increase the impact of screening but it is important to understand the elements contributing to an effective BAI; (iii) alcohol dependence is best treated by an integrated residential and community care program; (iv) military personnel on deployment and on return from deployment have special needs which need to be addressed. It cannot be stressed too strongly, however, that these are hypotheses are based on a scoping review of the literature and need to be rigorously tested using methodologically sound research strategies before any firmer conclusions can be reached.

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