Suicide Prevention and the Veteran Community

Craig's story

Craig (42) is sitting in his GP's consulting room, having made an appointment to request a repeat prescription for his pain meds. Unexpectedly, he reveals to the GP that the other night he found himself in his parents' shed in his uniform, after one too many drinks, playing with his father's shot gun and the idea of using it on himself.

Craig moved back to his parents' farm, outside Toowoomba, five months ago, after his long term girlfriend, Renee, kicked him out of the apartment they shared in Townsville.

Craig and Renee's relationship broke down following his medical discharge from the Army. Craig was in the Army for ten years working as a transport engineer in the infantry, and joined with Renee's encouragement. In his early 30s after the bitter break down of his 12 year relationship with childhood sweetheart Amy, he met Renee, who encouraged him to break the cycle of casual, unskilled labouring jobs he'd held all his adult life by joining the Army. Renee's younger brother, who was in the infantry, spoke highly of the military experience from the work to the camaraderie – and from day one Craig wasn't disappointed with his decision to join.

Craig loved being in the Army; the skills he was learning, the mates he was making, his new sense of purpose and the world he was seeing. Craig didn't have fond memories of his 20s. His relationship with Amy had been turbulent challenged by his drinking and financial difficulties. When Amy left him, he hit rock bottom, culminating in him taking an overdose of Panadol and Aspirin. It was a cry for help and immediately afterwards he was grateful, he hadn't taken anything stronger.

In comparison, Craig's 30s were a breeze. He met Renee when he was still raw and emotional from the break up with Amy. Their connection was immediate and he moved into Renee's apartment after only a couple of months. Renee understood Army life and she handled the long absences when he was on deployment in Afghanistan well. Meanwhile, Craig loved the thrill of deployments, but equally he looked forward to coming home when things were fresh and exciting between him and Renee.
In his last deployment, about two years ago, the jack holding up a truck he was working on collapsed and shattered his knee.

The Australian Defence Force (ADF) were great following the accident. They did everything they could to help him, including organising and covering all his medical and rehabilitation requirements. However his knee never reclaimed its full functioning, and to his bitter disappointment, he was medically discharged nine months ago. Craig felt like it wasn't only his knee, but also his dreams and his future that had been shattered.

Craig felt like a 'loser'. He couldn't throw the feeling that he was only half the man he used to be. His world closed in on him. It was like he felt safer when he had been on deployment or in the

barracks than he did now at home. He applied for a few jobs but was knocked back from all of them. The constant pain in his knee wore him down and he relied heavily on pain meds to cope. He found himself drinking to pass the time. Sometimes he'd just sit in the apartment all day, in his uniform, drinking and waiting for Renee to come home.

It didn't take Renee long to kick him out, giving him an ultimatum to stop wasting time feeling sorry for himself and find work. He couldn't believe that she'd kicked him out. Renee was all he had and now with nowhere to live, and a body that was tired and in constant pain, he felt his only option was to move back to his parents' farm, a place he hadn't been back to since he left school.

His parents were elderly and grappling with various age related health issues, but they still maintained the farm. They kept different hours to Craig, getting up before dawn and going to bed early. He couldn't bring himself to tell them about his discharge from the Army, nor about him and Renee, instead claiming he had chosen to come home to give them a much needed helping hand. However, rather than helping out, Craig spent most days sleeping in late, pottering around, lost in a fog of self-hatred and regret. The only things that took the edge off were his pain meds and alcohol.

Craig spent five months like this; in his own head space, drinking to kill the time, ruminating about how useless he was, no help to his parents, unemployable, with chronic pain in a body that felt old beyond its years, alone with no future prospects. He started to think that maybe the world would be a better place without him. What sort of man was a burden at 42? A loser, that's who.

Craig was both scared and relieved when he found his father's shotgun one day a couple of weeks ago. Scared, because it took him back to that place many years ago, when he took an overdose of Panadol and Aspirin after his breakup with Amy. He imagined how different things would have been if he'd just done the job properly relieved because he had a second chance to do it properly this time.

Now Craig woke up most mornings strangely excited. He had a plan, a way out, he hadn't felt this free in a long time. He just needed some more pain meds to even him out. So he made an appointment to see the local GP, the same one he'd seen throughout his childhood but hadn't seen for over 20 years.

There was something about the GP, he's not sure what, but when Craig finds himself sitting in the consulting room he feels an unexpected urge to share what happened in the shed with the gun.

He doesn't feel like he needs or wants help, or in fact that help would even change things, but in the back of his mind he has a nagging thought, that if he does go through with his plan, at least the GP will be able to fill in the gaps for his Mum and Dad. It's the least they deserve.

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This document answers the most common questions that remained outstanding at the webinar's conclusion.

Frequently Asked Questions

1. **What are some key steps for identifying that a client may be at risk of suicidality?**

When working with the veteran population, managing risk is a key priority. It is not always obvious from a client's presentation that they are having thoughts of suicide, which is why it is important to always ask directly about thoughts of death, dying and self-harm. Direct questions such as, "are you having thoughts of suicide?" or "are you having thoughts about taking your own life?" allow the veteran permission to tell you how they are feeling and avoid misunderstandings or client evasion.

When assessing client risk, a clinician needs to be clear about defining the features of a person's suicidal behaviour, such as suicidal thoughts, plan and intent, as well as protective factors. A standard risk assessment of harm to self can provide a baseline of information on which to assess the level of risk and inform actions required. However, suicide risk rarely presents as linear in nature. Rather it tends to shift between mild, moderate and severe. It is important for clinicians to better understand the defining features of risk in order to inform treatment for the individual. Utilising a suicide risk screening tool, such as the Screening Tool for Assessing Risk of Suicide (STARS), to collate information about the client's psycho-social situation and level of risk/warning signs is a key step in the evaluation of a veteran's risk of suicidality.

Through clinical research and experience, it is well known that there is not any one tool or approach that can be used accurately to predict suicide risk. Rather, it is acknowledged that key approaches to identify risk focus on listening to the veteran's story. Listening needs to take into account the individual circumstances of the veteran and consider these against a background of risk and protective factors, such as age and gender. As important as it is to take into account the fluctuating nature of risk, it is also important to incorporate the "here and now" understanding of the person's suicidality, including situational and contextual elements. Development of therapeutic alliance and consultation with their immediate support network, whether this be medical professionals or family and friends, is as important as exploring, identifying and addressing suicidality.

If a veteran reports significant risk, the clinician needs to mitigate the risk and enable the veteran to be safe. Such actions include; developing a safety plan that removes the means or access to the means to carry out a plan, identifies the supports that need to be notified and help organise emergency contacts, the safest place to be, triggers to thoughts of self-harm and self-care steps.

A list of useful numbers and services are available at http://www.mentalhealthcommission.gov.au/get-help.aspx and risk assessment questions are available at https://www.square.org.au/risk-assessment/risk-assessment-questions/

If a person is not a clinician but identifies an individual may be at risk, it is important to link the person to available supports such as a mental health professional. For veterans and their families, a good first step is to contact the Veterans and Veterans Families Counselling Service (VVCS) on 1800 011 046. If the person is at immediate risk, then it is important to call the local mental health crisis team, or call triple zero and ask for an ambulance. The mental health crisis team numbers across Australia are available here https://www.healthdirect.gov.au/crisis-management

2. **Are there strategies or types of interventions that are particularly helpful for veterans?**

Veterans present with a range of diverse issues, often related to the impact of military culture and experience. When providing support and treatment to veterans it is important to recognise and understand the impact of military culture and experience, in light of the presenting issues. With each client presentation, an individualised treatment plan should be developed to address the veteran's clinical and personal needs. There are a range of evidence-based interventions that can be used in clinical treatment e.g. Cognitive Behavioural Therapy, Trauma Informed Therapy and Crisis Intervention Therapy. It is also important to incorporate social and allied professional support as treatment progresses to address the veteran's needs holistically and comprehensively.

When considering the impact of military culture, it is important to reflect on how transition and reintegration into family and civilian life can impact on the individual. In addition to individualised clinical interventions, there are a range of workshops, family therapy, group programs and social support programs that can assist this cohort to understand their symptoms and behaviours and develop strategies to manage them effectively. A key group program is the Stepping out Transition Program. The program is for members transitioning from the ADF back to civilian life, and their partners for up to 12 months post separation.

Link: http://www.vvcs.gov.au/Services/GroupPrograms/stepping-out.htm

These interventions can be useful not only for the veteran but also for the veteran's family to understand mental health presentations and services to address their own needs. VVCS provide a range of services and individuals would be encouraged to contact VVCS on 1800 011 046 to discuss their particular circumstances and explore options for seeking support.

Please encourage your clients to visit the *At Ease* website which can help veterans, current serving military personnel and family members identify other symptoms of poor mental health, find self-help tools and advice, access professional support and learn about mental health treatment options. At Ease includes resources such as; High Res, Operation Life, PTSD Coach Australia and The Right Mix.

The Department of Veterans' Affairs (DVA) provides a range of training and resources for professionals working with veterans. DVA online provider training programs include; Understanding the Military Experience, Case Formulation and Treatment Planning, vetAWARE, PTSD - Psychological Interventions and Working with Veterans with Mental Health Problems for GPs. See https://at-ease.dva.gov.au/professionals for more information.

Health professionals have a key role delivering care to the veteran community. DVA is committed to providing you with the support you need to treat our clients with best practice, evidenced-based care, and to ensure that doing business with us is as easy as possible. Subscribe to **DVA Provider News** to receive the latest DVA information and updates, delivered to your inbox. See https://www.dva.gov.au/providers/dva-provider-news for more information.

3. **How can providers best work with veterans in rural/remote areas to provide long term support? What services are available?**

DVA is aware that a substantial number of veterans and their families are located in rural and remote locations across Australia. To address the needs of these veterans, VVCS has established a network

of outreach providers to service clients in rural and remote locations. Both DVA and VVCS also offer the option of skype and telehealth services which are regularly utilised by veterans living in remote areas or internationally and those that may have a Fly-in/Fly-out working roster. VVCS regions have established satellite offices to provide services to clients who cannot access the main regional office. DVA also has Veteran Access Network (VAN) offices in regional and remote areas.

A list of DVA and VVCS offices across Australia can be found here: https://www.dva.gov.au/contact/dva-office-and-client-service-locations.

DVA can provide eligible persons and their medically required attendants' assistance with travel to access treatment. Information on travel for treatment is available here: https://www.dva.gov.au/health-and-wellbeing/home-and-care/travel-treatment. If relevant, encourage the veteran and their supports to contact DVA to discuss further on 1800 550 455.

In addition to clinical services, VVCS also offer an all-hours crisis line for veterans and their families and a Facebook page which can be accessed online. Contact details of relevant all-hours crisis lines for current and former Australian Defence Force members and their families, include:

- Veterans and Veterans Families Counselling Service / Vetline 24hours access 1800 011 046
- All-hours Support Line 1800 628 036
- Defence Family Helpline 1800 624 608
- 1800 IM SICK 1800 467 425

When working with rural and remote veterans, it is important to establish and maintain client engagement through a network of medical and social supports. This increases their access to service provision and reduce the veteran's isolation and potential risk of suicide. In addition to the clinical supports, VVCS has recently established a Peer Community Engagement team to:

- Develop a network of social and community supports;
- Engage with the community to identify veterans and family members in need of support who may not engage directly with clinical services; and
- Connect clients with support within their local community.

There are also a range of non-veteran specific services available to support people with mental health concerns in rural and remote areas. Initial engagement is often through a medical practitioner or local GP, who can connect individuals to available supports in the local area via a referral and mental health plan. Psychological services can be delivered via video and teleconferencing by psychologists in private practice and are subsidised by Medicare for up to seven sessions within a calendar year. Further information is available at: https://www.psychology.org.au/getmedia/fd748495-90e7-40d8-bedb-c3d7999cbb2d/18APS-Telehealth-Consumers.pdf

The mental health crisis team for the State/Territory can also advise about local services, contact numbers for the crisis teams in each State/Territory are here https://www.healthdirect.gov.au/crisis-management

Head to Health is a national website that can direct people to high quality online resources and services to support mental health https://headtohealth.gov.au/

4. What support is available for families and children of a veteran suffering mental health issues or is at risk of suicide?

Families often are the first to notice when their loved ones may need additional support or mental health treatment, and helping their veteran or serving member to access support can sometimes be challenging. A good first step is for families to contact VVCS on 1800 011 046 to discuss their

particular circumstances and explore options for seeking support. If the veteran is open to participating in the call, this can help them to make a direct link to VVCS and to initiate treatment-seeking for themselves.

If the veteran or serving member is reluctant to seek help, it is still important for family members to access support for themselves. Calling VVCS is a good option to seek assistance. To complement counselling services, VVCS offers a range of group programs open to family members. These groups provide a safe and supportive environment in which to learn about issues impacting on mental health and wellbeing, and to learn self-care strategies and techniques for better supporting themselves and their families.

Link: http://www.vvcs.gov.au/Services/GroupPrograms/group-calendar.htm

The Defence Community Organisation (DCO) provides a number of resources to support families, including story books, Children of Parents with a Mental Illness (COPMI) national initiative resources and can make appropriate referrals. In addition, DCO staff can provide support to parents to assist them in supporting children in the family.

The Australian Kookaburra Kids Foundation supports kids living in families affected by mental illness. The program provides recreational and educational camps and other activities, giving kids a break in a fun, positive and safe environment. The Government announced funding of $2.1 million in March for the Foundation to run a two-year pilot program to help children of current and former ADF members. You can refer a child to the program through the website below, information supplied on the form is kept strictly confidential.

Link: https://kookaburrakids.org.au/how-you-can-help/refer-a-child/

There are also a number of services available to families following a suicide death or a non-fatal attempt. In these circumstances, please encourage your clients to contact DVA on 1800 550 455 to discuss further.

There are also a number of community support services available, these include:

- Postvention Australia: https://postventionaustralia.org/
- Standby support services: http://standbysupport.com.au/

5. What is peer support and how do I find it?

Peer support is when people provide knowledge, experience and emotional, social or practical help to each other. In the area of mental health and suicide prevention, it usually refers to people with lived experience of mental illness and recovery providing support to others experiencing similar issues.

VVCS have Peer Advisors who offer individual support to VVCS clients who request their services (mentoring / coaching / shared experience information exchange). Peer Advisors offer a lived experience perspective on issues that can impact on health and wellbeing. Through shared experiences they are able to offer support and referral connections for veterans and their family members. One of the main objectives of peer support is to enhance the management of complex and/or high risk clients.

The VVCS peer support network is established through ADF, veterans and community members, who have an interest in supporting veterans, their families and supports. Some members represent an Ex-service Organisation (ESO), whilst others are friends or colleagues of veterans or their families. The focus of the peer network is to provide participants with the skills to identify at risk individuals and to offer them appropriate support to access the help they may need. This is also a way to provide social support for veterans and their families whilst they are waiting to engage with counselling services.

There are many other sources of formal and informal peer support. Individuals may find informal support from peers in their existing networks, such as friends and family. Formal support can also be

found via a range of other organisations, such as Head to Health https://headtohealth.gov.au/ and The Black Dog Institute https://www.blackdoginstitute.org.au/getting-help/clinics-support-groups/other-support-groups

6. What strategies can be used to encourage veterans to stay engaged in their treatment?

Veterans and their families dealing with a mental health issues can be difficult to engage in ongoing treatment. When working with any veteran, it is important to prioritise autonomy, empowerment and respect for the individual who is receiving the service whilst therapeutic rapport develops. When working with veterans and their families, it is beneficial to demonstrate an understanding of the impact of military culture and experience.

You can improve your understanding of the military experience by completing the DVA free eLearning course, *Understanding the Military Experience*. You can access this course on the At Ease Professional website: https://at-ease.dva.gov.au/professionals/professional-development/dva-courses-and-programs. You can also watch the first webinar, *Understanding the Military Experience: From Warrior to Civilian*, on the At Ease Professional website: https://at-ease.dva.gov.au/professionals/professional-development/dva-webinars.

There are numerous variables which may affect a veteran's level of treatment engagement, including therapeutic alliance, accessibility of care and trust in treatment effectiveness. Recovery-oriented care respects an individual's goals and plans for the future. The veteran and their supports are partners in care. Personalised care focuses on an individual's unique goals and life circumstances and tends to encourage continued care involvement and motivation towards health self-management.

7. Can I, as a health provider, treat current ADF personnel?

Defence provides health services through an integrated workforce of ADF members, civilians, contractors and professional health providers. The primary contract is delivered by Medibank Health Services through the Garrison Health Services contract. The Garrison Health Services provider network consists of a comprehensive nation-wide group of over 4500 medical specialists, 9000 allied health professionals and 250 working hospitals. Eligible health care workers are encouraged to join the Garrison Health Services provider network.

A referral form authorises an ADF member to see you for treatment. This form is completed by the referring Medical Officer and will contain a Defence Approval Number (DAN). The DAN is pre-approval that ADF personnel are eligible to receive a health service. It is also authorisation for Medibank Garrison Health Services to pay an invoice on behalf of the ADF. This number must appear on all invoices. The DAN is generally six digits, however in some cases it may include a prefix followed by six digits.

In emergency situations a DAN may not be available. In these circumstances please ensure that 'No DAN provided' is clearly stipulated on the invoice. The only time ADF personnel will arrive for treatment without a referral form is in the case of an emergency. In clinically urgent circumstances additional ADF approval or direction can be sought via a phone call to the referring ADF On-base Health Centre or relevant regional headquarters. However, attempts to gain additional approval should not impede the clinical priority to treat the patient. For further information, please call 1300 126 420 or email adfenquiries@medibank.com.au.

Defence also delivers a comprehensive Suicide Prevention Program, this includes; Keep Your Mates Safe workshops for junior leaders, command presentations and a two-day Applied Suicide Intervention Skills Training program. Further information about the ADF Suicide Prevention Program can be found here: http://www.defence.gov.au/Health/DMH/SuicidePreventionProgram.asp

8. **How can providers assist their veteran patients to find networking opportunities to prevent isolation (such as volunteering, employment opportunities, peer support, ESO networks)?**

   There are a range of organisations that offer networking and engagement opportunities for veterans and their families. Providers are encouraged to contact the local VVCS or DVA office, DCO or ESO to explore what activities or programs are available for their clients. VVCS Peer Community Engagement officers can also assist providers to identify links for the veteran and their family in the community. DVA also delivers the Heart Health program, which provide veterans with an opportunity to engage in physical activities within a social environment.

   Approved DVA rehabilitation programs support psycho-social activities for veterans to encourage social involvement. Programs assist veterans to build skills, confidence and social networks whether through recreational participation, volunteering, training and/or employment opportunities.

   More information about DVA Rehabilitation programs can be found here:

   - https://www.dva.gov.au/factsheet-mrc05-rehabilitation
   - https://www.dva.gov.au/sites/default/files/files/publications/health/Rehabilitation_Brochure.pdf

   There are many organisation that offer social activities, volunteer opportunities and charity events which veterans and their families can attend. Opportunities may be available through engagement with Solider On, Mate 4 Mates, Defence Family, Partners of Veterans Association, Defence Community Organisation to name a few.

   Veterans are also able to access local community-based activities, however these may not be veteran specific. You can receive further information about these activities by contacting the Local Government office in your area.

   It is important for veterans and their families to be able to access services that are culturally sensitive and reflect their values, beliefs and personal identity. There are 143 Aboriginal Community Controlled Health services across the country which service health and wellbeing issues for Aboriginal people.

   Further information can be found here: https://www.naccho.org.au/.

Suicide Prevention and the Veteran Community

Webinar panellists

Ms Carmen Betterridge
Psychologist

Carmen is the Director of and Principal Psychologist with Suicide Risk Assessment Australia, a provider of training, supervision and consultation services, delivered across corporate, Government and non-Government sectors.

Carmen is a member of the APS Suicide Working Group, and the International Committee for Guidelines on the Impact of Client Suicide and Suicidality on Workers.

Carmen is a lecturer, consultant facilitator and researcher with the Australian Institute for Suicide Research and Prevention, and continues to provide expert witness reports across multiple medico-legal settings.

Carmen holds postgraduate qualifications in indigenous health, forensic mental health and suicidology.

Associate Professor Grant Blashki
General Practitioner

Dr Grant Blashki is a practicing GP and lead clinical advisor for beyondblue.

He is currently Associate Professor at The University of Melbourne and has more than two decades of involvement in the primary mental health field including as writer (lead editor of *General Practice Psychiatry*), educator (Masters of General Practice Psychiatry), policy advisor and evaluator (The Better Outcomes and Better Access programs) and researcher (more than 125 peer reviewed journal articles).

Grant is an Honorary Professor at Luohu Hospital in Shenzhen and trains GPs in China a number of times a year.

Dr Richard Magtengaard
Psychiatrist

Dr Richard Magtengaard is the current Director of the Military Trauma Recovery Programme at the Marian Centre (a 69 bed private hospital in Perth, Western Australia). This programme is suitable for Defence personnel, veterans and other professionals including police officers, paramedics and those who have also endured ongoing trauma within the performance of their duties.

Dr Magtengaard served for 10 years as a Commissioned Officer within the Royal Australian Navy before moving on to practice medicine and becoming a consultant psychiatrist.

He remains an active member of the Australasian Military Medical Association (AMMA) and his team has developed affiliations with the ADF Joint Health Command (JHC), St John's Ambulance (SJA) and WAPOL.

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He remains committed to the mental health and general wellbeing of Defence personnel and veterans, alongside our first responders and their families.

Facilitator

Professor Mark Creamer
Clinical Psychologist

Professor Mark Creamer is a clinical and consulting psychologist with over 30 years' experience in the field of posttraumatic mental health.

Mark is internationally recognised for his work in the field; providing policy advice, training and research consultancy to government and non-government organisations, with the aim of improving the recognition, prevention and treatment of psychological problems following stressful life events.

Mark is a Professorial Fellow in the Department of Psychiatry at The University of Melbourne, and has an impressive research record with over 180 publications.

Mark is an accomplished speaker and has given numerous invited addresses at national and international conferences.