Submission to the National Mental Health Commission

Review of the services available to veterans and members of the Australian Defence Force in relation to the prevention of self-harm and suicide.

Australian College of Mental Health Nurses
The Australian College of Mental Health Nurses (ACMHN) welcomes the opportunity to provide a submission to the National Mental Health Commission Review of the services available to veterans and members of the Australian Defence Force in relation to the prevention of self-harm and suicide.

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Our Organisation

The Australian College of Mental Health Nurses (ACMHN) is the peak professional organisation representing mental health nurses in Australia. A primary objective of the ACMHN is to enhance the mental health of the community through the pursuit of efforts to improve service and care delivery to those affected by mental illness and disorder. The ACMHN also sets standards of practice for the profession and promotes best practice in mental health nursing.

ACMHN has been involved in activities as part of its advocacy to improve the accessibility and quality of mental health services to veterans and members of the Australian Defence Force (ADF), including:

- Providing feedback to support the development of mental health tools and resources that were developed by Lifeline in Consultation with the Department of Veteran’s Affairs (DVA) (2011).

1. Introduction

The ACMHN acknowledges the Terms of Reference (TOR) for the Review, which covers the services available to veterans and members of the ADF in relation to the prevention of self-harm and suicide.

This submission will focus on a number of key issues that are relevant to the TOR:

- The range of services available to current and former serving members and their families
- The effectiveness of these services in supporting members and their families while they serve, as they transition from Defence to civilian life, and later in their civilian life
- Any duplication or gaps in current services and how they might be addressed
- Any barriers to current and former serving members accessing services, taking into account cultural relevance, availability of providers, employment, functional capacity and degree of ill health

The ACMHN has noted the relatively limited academic research available on the risk of self-harm and suicide amongst members of the ADF and veterans in Australia, but notes that the ADF states that the rate of suicide of those serving in the ADF is lower than the national average when matched for age and gender. While it is likely not appropriate to extrapolate rates of self-harm and suicide in amongst ADF members and Veterans in Australia from the United States evidence, it is still reasonable to assume that the risk factors identified through the American research have some applicability in Australia.

The ACMHN acknowledges that the ADF Mental Health and Wellbeing Strategy 2016-2020 and the ADF Mental Health and Wellbeing Plan, which aims to:

- Address stigma and barriers to care
- Strengthen mental health screening continuum
- Improve pathways to care
- Develop e-mental health approaches
- Develop a comprehensive peer support network
- Enhance service delivery
- Upskill service providers

and its six key mental health initiatives:

- Integration and Enhancement of ADF Mental Health Services
• ADF Mental Health Research and Surveillance
• Enhanced Resilience and Wellbeing in the ADF
• ADF Critical Incident Mental Health Support
• ADF Suicide Prevention Program
• Alcohol, Tobacco and Other Drug Program

The ACMHN also acknowledges that the ADF has identified the need to improve policy and training for ADF mental health professionals, established the ADF Centre for Mental Health, delivered a MOU between the DVA and ADF, undertaken research alliances, established e-mental health supports such as the smartphone app and the ‘At Ease’ portal – through which the ADF promotes its mental health and psychology services, prevention initiatives, awareness and education programs and its crisis support and recovery programs. In focusing particularly on suicide prevention, the ADF is to be commended for its development of a four-level suicide prevention program.

What does not seem clear from the available ADF information is the range of services available to current and former serving members and their families that encompass early identification of those at-risk of developing a mental health condition and who have experienced trauma.

The ACMHN acknowledges that the ADF promotes the use of a trauma informed approach in specific ADF services. For example, SeMPRO operates in a trauma informed manner to deliver best practice support to those affected by sexual misconduct. It is also clear that the ‘At Ease’ professional website recognises the importance of a trauma informed approach to working with military personnel, particularly veterans. The website identifies various training programs in trauma recovery for health professionals working in the community with ex-military personnel.

As the ADF clearly understands, services should have streamlined access and multiple pathways for referral to evidence-based, effective mental health interventions delivered by an appropriately qualified and experienced mental health professional. Prevention of self-harm and suicide begins long before a mental health condition is identified and would ideally start with mental health promotion interventions throughout ADF training, prior to and following a deployment. From there, self-harm and suicide prevention interventions should continue throughout the entire stepped care spectrum; drawing on the approach depicted in Figure 5 of the *NMHC National Review of Mental Health Programs and Services* (2014).

### 2. The range of services available to current and former serving members and their families

The practice of all nurses in Australia is framed by the regulatory requirements of the Nursing and Midwifery Board of Australia (NMBA), including adherence to relevant competency standards and decision-making frameworks, currency of practice and professional practice and development.

Guidance on the practice of all mental health nurses (MHN) in Australia is provided by the ACMHN Standards of Practice for Australian Mental Health Nurses 2010 and the ACMHN Scope of Practice of Mental Health Nurses in Australia 2013. While any Registered Nurse may work in a mental health setting, the ACMHN defines MHN as a Registered Nurse who holds a recognised specialist qualification in mental health (nursing).

MHN’s perform a wide-range of roles, functions and activities, from promoting optimal mental health, preventing physical and mental ill health, and providing evidence-based therapeutic interventions. Taking a holistic approach, guided by evidence, the MHN works in collaboration with people who are experiencing mental ill health, their family and community, towards recovery as defined by the individual. The skills and qualifications of MHN facilitate opportunities to provide prevention and evidence-based interventions across all levels of stepped care; from mental health...
promotion, through to specific clinical interventions targeting people who are experiencing a mental health crisis and may be at elevated risk of self-harm and suicide. A trauma informed, person-centred and recovery-focused approach to care is core business for mental health nursing, and underpins all clinical interactions, at all levels of care and across the entire lifespan.

Although MHN do exist in the ADF, a past Ministerial Review of the provision of mental health care in the ADF (2009) identified that mental health nurses are commonly employed within community based health and mental health teams within civilian services, but much less frequently in the ADF. This may be due to a significant current and future shortage of mental health nurses in Australia.

The Ministerial Review also noted that remuneration of nurses with specialist qualifications and experience in mental health was comparatively low in the ADF and recommended that mental health nurses be employed with ADF regional mental health units, working alongside medical officers, psychologists and psychiatrists.

**ACMHN Recommendation:** That the ADF and DVA work with ACMHN to establish a more robust mental health nursing workforce able to provide specialist interventions in the treatment of trauma and reduce risk of self-harm and suicide amongst ADF members and former members, across the stepped care spectrum – from health promotion and prevention, to ongoing treatment.

**ACMHN Recommendation:** That the ADF and DVA develop the mental health skills of the existing ADF nursing workforce, so that all nurses working in ADF settings can become more skilled in identifying mental health issues associated with work in the military.

3. **The effectiveness of these services in supporting members and their families while they serve, as they transition from Defence to civilian life, and later in their civilian life**

Involvement in or exposure to a deeply distressing event or experience, a ‘single incident trauma’ such as a life-threatening event can cause emotional shock that has long-lasting effects on a person’s thoughts, feelings and behaviours. The term ‘complex trauma’ describes multiple kinds of adversity and overwhelming life experiences. The cumulative effects of this type of trauma are pervasive and represent major risk for lifelong physical and mental illness, poor quality of life and even premature death (MHPOD 2011). Former and existing military personnel are likely to experience primary and complex trauma in the course of their service due to the nature of the work.

Post Traumatic Stress Disorder (PTSD) – where triggers such as physical or mental reminders of the traumatic event (e.g. smells, sounds, sights), cause the person to re-live or re-experience the traumatic event(s) – is a common consequence for many Defence Force members and former members (Department of Defence, 2010). Findings broadly linking a diagnosis of PTSD to risk of suicide have been mixed (Dobscha, S.K. et al, 2014). However, PTSD has been associated with increased risk of suicide, suicidal ideation and self-harm, specifically where it is undiagnosed or where treatment has not been received (Kang & Bullman, 2008; Zivin et al, 2007). Reducing stigma and addressing fears of missed professional opportunities therefore plays a significant role in the prevention of self-harm and suicide.

Kelly, et al. (2014) discussed a range of risk factors for PTSD amongst military personnel, including multiple deployments, increasing exposure to combat, being shot at or injured, witnessing violence or others being injured or killed. Killing during combat has also been linked to suicidal ideation and PTSD (Maguen et al, 2012). Further, people who have experienced trauma are more likely to engage in risk taking behaviours and are at greater risk for physical problems and premature death (Kezelman & Stavropoulos, 2012, p42). Other risk factors for self-harm and suicide that have been identified amongst veterans include mood and substance abuse disorders and poor physical health, such as pain and/or disability from injury (York et al, 2013).
The response of the ADF in managing the trauma experienced by its members is paramount. A blanket approach will not prevent all personnel identified as showing signs of trauma from engaging in active service, particularly because people respond to trauma differently and may be experiencing symptoms that are more difficult to detect. It is also common for people who have trauma to experience a significant delay in symptoms appearing.

The prevalence of exposure to physical abuse during childhood in Australia is estimated to be between 5-10%; with 2-12% of these children experiencing significant neglect, 6-17% being emotionally maltreated, 4-23% experiencing family violence, and 1-45% of children experiencing sexually abusive behaviour (depending on definition 1.4-8% of males experiencing penetrative abuse and 5.7-16% experiencing non-penetrative abuse, and 4-12% of females experiencing penetrative abuse and 13.9-36% experiencing non-penetrative abuse) (CFCA Resource Sheet July 2013)\textsuperscript{12}. It is also clear that a significant proportion of ADF personnel will enter the defence force with a pre-existing traumatic life history, upon which cumulative trauma will likely occur through the course of military work. Servicemen and women who report prior trauma (unrelated to service) have been shown to be more likely to experience new onset PTSD symptoms following a deployment than those who have not reported prior trauma (Smith et al, 2008)\textsuperscript{12b}.

The ADF cannot control the level of trauma people have experienced in the course of their lives outside the defence force; nor can it seek to exclude all individuals who have trauma from participating in active duty. The solution lies in the ADF and DVA investing in evidence based interventions that seek to support all ADF members and former members, as well as providing more intensive, targeted interventions for members who are at increased risk (such as following combat), or who are already experiencing symptoms of mental health conditions such as depression, anxiety and PTSD.

**Trauma informed care**

A trauma informed response includes understanding the person and the mental health issues they experience in the context of responses to trauma. It recognises that many people accessing health services more broadly have experienced trauma and takes this into account when understanding their symptoms, as well as in care delivery\textsuperscript{12c}.

Australia’s mental health and human service systems have, generally speaking, a poor record in recognising the relationship between trauma and the development of mental health conditions, co-existing difficulties and complex psychosocial problems, and responding appropriately to them. The lack of policy focus is reflected by a lack of awareness and education around trauma-informed approaches within practice and service settings (Taylor et al, 2008)\textsuperscript{12d}.

What is not clear from the ADF mental health and wellbeing documentation, is how broadly the ADF and health services delivered through funding from the Department of Veteran’s Affairs utilise a trauma informed response. Given the likelihood of prior trauma, a trauma informed response towards new recruits as well as existing personnel, would mean that all health providers, as well as the ADF more broadly, presume a level of trauma exists for all and understands the potential impact of any subsequent trauma on all existing and former members.

This requires education and action at all levels of the ADF about the various responses to trauma and when to seek help, whether that be for the individual themselves or someone else. A broader application of a trauma informed approach towards personnel who have not yet been deployed would likely assist in improving short- and longer-term outcomes.
Where intervention strategies delivered by a mental health professional are only targeted towards those with severe and noticeable symptoms, such as where there are concerns about an individual’s ability to perform duties, opportunities for prevention and improved health and workplace outcomes may be missed.

For example, rather than focusing specifically on mental health providers and on post-deployment personnel in a ‘diagnose and treat’ approach, all health personnel (e.g. medical practitioners, general nurses, physiotherapists) employed by the ADF or delivering services through the DVA should be trained in a trauma informed approach. Prevention opportunities exist at all levels of illness severity and at all points throughout and following a member or former member’s service. Mental health nurses can improve outcome for existing and former members at each of these opportunities. A trauma informed approach also encourages health professionals more broadly to recognise that an existing or former member who has been assessed as ‘not currently’ experiencing trauma following a deployment, or upon becoming a civilian, still carries a future risk. This is an important consideration since symptoms of trauma may not appear for some time and may be influenced by other aspects of the member or veteran’s life outside of their service.

Awareness of the concept surrounding a trauma-informed approach also needs to be built among ADF leaders and other key (non-health) personnel. Where the presumption is that every person in the ADF setting may have been exposed to prior abuse, violence, neglect or other traumatic experience, and that every experience of deployment will carry with it risk of exposure to further traumatic experiences, there will be an increased capacity to recognise the possibility of pre-existing trauma, and to identify the signs of a trauma response in the context of active duty and in between postings.

Broader exposure to trauma-informed practice training would also assist in the de-stigmatisation of trauma by improving all ADF personnel’s appreciation of how trauma may impact on physical health outcomes - such as the impact of trauma on recovery from an injury, or on increasing the risk of exposure to further traumatic experiences, there will be an increased capacity to recognise the possibility of pre-existing trauma, and to identify the signs of a trauma response in the context of active duty and in between postings.

Intervention opportunities need to target all members during training; as well as prior to, during and following deployment. Community based support groups and the full spectrum of health services provide further opportunities for veterans, and for their families. More targeted interventions, in the form of access to services delivered by a mental health nurse, psychologist or psychiatrist, should be made available to those identified to be at higher risk, or who are already experiencing symptoms of trauma or PTSD. The mental health nursing scope of practice addresses prevention and mental health promotion, as well as active treatment. With planning and investment the mental health nurse workforce would be a cost effective and accessible group of mental health practitioners. Mental health nurses can also provide support and mentoring to nurses working in generalist settings, to increase their mental health literacy and reduce professional stigma among the broader health workforce, which may pose a barrier to working in a trauma-informed way.

ACMHN Recommendation: That the ADF and its personnel seek to better understand why a trauma-informed care approach is important to the prevention of self-harm and suicide and explore how such an approach can be implemented across the entire course of service - from training, through to deployment, upon return from deployment and upon exiting the ADF.
ACMHN Recommendation: That the ADF and DVA seek to better integrate a trauma informed approach across all health activities and across the full scope of health services (not just providers of mental health services). This should include educating medical practitioners and other health care providers, about the impact of trauma on mental health and the available referral pathways if they have concerns about a member or former member.

ACMHN Recommendation: That the ADF seek to increase the mental health literacy of all ADF employees, in particular ADF leaders and key personnel, with a focus on a trauma informed approach.

ACMHN Recommendation: That the ADF and DVA engage with the ACMHN to establish a mental health nursing workforce which can implement a trauma informed approach across all health services, and can support more integrated care provided by generalist nurses across all health settings.

4. Any duplication or gaps in current services and how they might be addressed

There is an opportunity to improve screening processes for identifying existing or former members of the ADF at risk of self-harm or suicide. Mental health services should not rely predominantly on members and veterans self-referring, particularly as self-stigma and mental health related stigma remain problematic – not just for the ADF community, but for the community at large. New pathways for referral to mental health services need to be created which utilise the existing ADF and veterans’ health workforce, and which also enhance opportunities for access to mental health assessment and support. Referrals can also be made from other health professionals, including medical officers, nurses and other allied health professionals such as physiotherapists, or from family members who may be concerned and who, in all likelihood are witness to the less public face of the individual who is experiencing the repercussions of trauma. Mental health literacy activities and mental health training for the general health workforce as described above, which focuses on trauma informed care in the military is one way that pathways for referral and opportunities to engage with a mental health service can be increased.

Nurses are accessible and acceptable health practitioners to many health care consumers. They are well placed to help build an accessible, sustainable and effective stepped care response to mental health. An opportunity to break down some of the barriers to service access and increasing referral pathways lies in having all existing nurses employed with the ADF participate in basic mental health training centred around a trauma-informed care approach. This would provide every nurse with the skills to identify those at risk, identify those presenting with mental health symptoms, conduct an initial assessment using evidence based rating scales and refer as appropriate. Nurses with mental health training appropriate to their scope of practice, could work in collaboration with specialist mental health nurses to engage in mental health promotion and activities targeting the prevention of self-harm and suicide. An adequately prepared nursing workforce is well placed to provide appropriate support and interventions for clients experiencing various levels of distress and in response to changing needs.

A gap appears to exist in the provision of mental health service to members and veterans who have a physical illness or injury. Existing members and veterans who sustain an injury or develop a chronic illness during their service, are at increased risk of suicide (York et al, 2013). Trauma associated with the event that led to the injury or illness may add an additional layer of complexity to symptom presentation and treatment. The Senate Foreign Affairs, Defence and Trade References Committee noted in its 2016 report on the Mental Health of Australian Defence Force Members and
Veterans noted that the presence of a traumatic brain injury should be recognised as a causal or contributing factor of mental health concerns amongst ADF members and veterans\textsuperscript{xiii}. Symptoms and risk of self-harm and suicide may be further exacerbated by alcohol and drug misuse, which for some members or veterans may arise following a traumatic combat incident (or series of incidents), or an injury sustained during service.

A gap also appears to exist for veterans where access to health services may be provided through DVA via a ‘white card’ for specific conditions, such as PTSD, Anxiety Disorder or Depressive Disorder. It appears that access to mental health services is quite limited unless veterans have been diagnosed as having an ‘approved’ mental health disorder. This is a missed opportunity for prevention for veterans who have perhaps recently begun showing symptoms of trauma, but whose symptoms have not yet reached a level of severity indicating a specific diagnosis. Access to specialist mental health services through DVA should not require a specific diagnosis of an ‘approved’ mental health disorder. Making these services also available to veterans who may have begun to show signs of trauma (for example, a veteran whose family have recently started to become concerned), may potentially prevent symptoms from becoming more severe and shorten recovery time.

Mental health nurses take a holistic approach to improving mental health. This includes identifying interactions that may exist between mental and physical health conditions and working with the individual to establish a treatment plan that meets all of their needs. The role of the mental health nurse is to understand and respond to all contributing factors affecting a person’s mental health. Independent evaluations of mental health nursing services delivered in community settings under the Medicare funded Mental Health Nurse Incentive Program (MHNIP) found individuals who received support from a mental health nurse were less likely to require hospitalisation and more likely to return to employment, education and participate in social activities. Mental health nurses were also able to improve physical health and provide coordinated care for people with comorbid conditions, such as drug or alcohol abuse, physical illness or disability, in addition to treating the mental health condition\textsuperscript{xiii}.

A mental health nursing workforce has the specialist skills to respond to mental health needs in the context of trauma-informed care and alongside any physical health conditions or injuries the existing or former member may have. An opportunity exists for the ADF and DVA to build a mental health nursing workforce which can be posted overseas and can also provide services within a community mental health model, including to existing and former personnel, back in Australia. The ACMHN can assist with this process.

**ACMHN Recommendation:** That the ADF seek to establish specific career pathways to facilitate more mental health nurses being employed by the ADF and to create ADF supported transition pathways for general nurses to become appropriately qualified and experienced mental health nurses.

**ACMHN Recommendation:** That the DVA expand the eligibility criteria for access to specialist mental health services to incorporate symptoms of trauma, where PTSD, an anxiety or depressive disorder or alcohol or substance use disorder has not been diagnosed.

**ACMHN Recommendation:** That the DVA take a more active approach to incorporating mental health nursing services into mental health programs, and develop a program through which appropriately qualified and experienced mental health nurses can deliver clinical mental health interventions to veterans experiencing the affects of trauma, including PTSD, depression, self-harm and suicidal ideation.
**ACMHN Recommendation:** That the ADF and DVA work with the ACMHN to establish a mental health scope of practice for all nurses working within the ADF (including ENs and RNs working in generalist specialties and across all settings); and then, provide suitable introductory level professional education for the existing nursing workforce.

**ACMHN Recommendation:** That DVA actively promote and educate GPs and other providers about the potential impact of trauma on veterans and the appropriate referral pathways to a more specialist mental health service.

5. **Any barriers to current and former serving members accessing services, taking into account cultural relevance, availability of providers, employment, functional capacity and degree of ill health**

The possibility that symptoms may not appear immediately (or for years afterwards) following a traumatic event or period of prolonged acute stress, poses a significant barrier to those in need of support.

Stigma also continues to be a barrier for serving members and veterans. The prevailing culture of the defence force is one of strength and stoicism. In this environment, expressing thoughts and feelings in response to traumatic events may be unlikely. Cultural change is required and could include a range of approaches, for example:

- Focusing training on physical and mental strength as well as a personal responsibility (and the responsibility to one’s colleagues) of taking reasonable steps to look after one’s own mental health and wellbeing
- A zero tolerance approach to the use of stigmatising language around emotional responses to traumatic experiences
- Including mental health assessment and treatment as part of everyday health care for all ADF employees – with the trauma informed approach as the central component. Normalising the process of seeing a mental health professional, such a mental health nurse, psychologist or psychiatrist; and noting that nurses are an accessible and acceptable health professional group
- Incorporating ‘trauma recovery’ work into the ‘role’ or ‘job description’ of every exemplary ADF employee – to ensure they are ‘the best’ they can be

In order for such an attitude change to occur, the ADF must take active steps to address the reluctance of members to seek support or treatment for a mental health concern. Many members of the military fear that accessing any form of mental health service will adversely affect future deployment opportunities, as well as future opportunities for career progression (Stecker, Fortney, Hamilton, & Ajzen, 2007). It is the responsibility of the ADF to address these concerns and implement policies and process that will ensure that decisions around members’ future service opportunities are impacted only by what is operationally and clinically appropriate. The fact that a member has accessed mental health services in the past should not automatically reduce their future opportunities in the ADF. Indeed, given the high incidence of exposure to trauma, the ADF should be particularly concerned that potentially significant numbers of its personnel who would benefit from some form of treatment are being redeployed and promoted, without having received treatment at all.

Evaluations of the Mental Health Nurse Incentive Program found that the mental health nurses helped to reduce stigma still often associated with seeking mental health treatment. Clients identified they felt less stigma about seeing a mental health nurse, who is able to operate...
collaboratively within a diverse clinical team that may include general practitioners, general practice nurses, psychologists and psychiatrists and physiotherapists.

An additional barrier that exists for all current and former serving members relates to the state of their mental health itself. Services which predominantly rely on people experiencing a mental health concern to self-refer fail to recognise that some mental health conditions may involve a reduced ability to have insight into the presence or severity of one’s own illness and the need to seek treatment, or that shame and fear may inhibit access. A trauma-informed approach, coupled with a nursing workforce trained in mental health assessment appropriate to their scope of practice, will open more pathways for referral and facilitate more timely intervention.

ACMHN Recommendation: That ADF training establishes and instils a culture which encourages and promotes self-care alongside courage and sacrifice, with the underlying message that you cannot properly serve your country, look out for your mates, or look after your family if you do not also take reasonable steps to look after yourself.

ACMHN Recommendation: That the ADF implement clear policies and procedures to guide situations where it may be appropriate or necessary to consider past mental health, including the development of strict criteria and controls around decisions impacting on future career opportunities such as redeployment or promotion.

ACMHN Recommendation: That all deployed troops participate in mental health promotion training prior to deployment and mental health counselling upon return to Australia

ACMHN Recommendation: That the ADF and DVA engage mental health nurses to undertake cost effective and accessible specialist mental health care for all pre- and post-deployment personnel

It is the position of ACMHN that mental health nurses are in a position to fill existing gaps in service provision for the prevention of self-harm and suicide, while also reducing the stigma that may often still be associated with accessing a mental health service. However, the effectiveness of and accessibility to mental health services is also dependent on the ADF and DVA making significant changes to culture, policies and procedures.

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5 Dunt, D., (2009). Review of Mental Health Care in the ADF and Transition through Discharge. Commissioned by the Minister for Defence Science and Personnel, the Hon Warren Snowdon MP, and the Minister for Veterans’ Affairs, the Hon Alan Griffin MP.
7 MHPOD, (2012). Course: Trauma and Mental Health. Produced by Cadre Pty. Ltd. and the Psychosocial Research Centre of the University of Melbourne for the Project Steering Committee, on behalf of the Mental Health Workforce Advisory Committee (MHWA). Copyright: Cadre Pty. Ltd., Sydney.


