Royal Commission into Defence and Veteran Suicide

PHN Cooperative Submission

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Primary Health Network (PHN) Cooperative

Contents

1. Introduction

1.1 Background

Australia's 31 Primary Health Networks (PHNs) are independent organisations funded by the Federal Department of Health (DoH). They work to coordinate care so that people in the community have access to the right care, in the right place, at the right time.[1] As stewards of the primary health care sector, PHNs assess the needs of the populations in their regions, and commission health services to improve quality, access and equity in their respective regions. This includes:[2]

- assessing the health needs of their region using a people-centred approach
- commissioning health services to meet the needs of people in their regions and address gaps in primary health care
- working closely with primary health care practitioners and providers to build the capacity of the health workforce to deliver high-quality care
- integrating health services at the local level to create a better experience for people, encourage better use of health resources, and eliminate service duplication.

There is currently a critical opportunity to leverage the strengths of PHNs in addressing the needs of ex-serving Australian Defence Force (ADF) members within the primary health care system. This includes increasing the awareness and engagement levels of ex-serving ADF members with primary health care to improve mental health outcomes, as outlined in this submission. A summary of the submission development process can be found at Appendix 1. This submission addresses the following terms of reference:

Section/s	Terms of Reference
1.2	Systemic issues and any common themes among defence and veteran deaths by suicide, or defence members and veterans who have other lived experience of suicide behaviour or risk factors (including attempted or contemplated suicide, feelings of suicide or poor mental health outcomes);
1.2, 3.1, 3.2, 3.3	A systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues, such as the following: • the manner or time in which the defence member or veteran was recruited to the [the Australian Defence Force (the ADF)]; • the relevance, if any, of the particular branch, service or posting history, or the rank of the defence member or veteran; • the manner or time in which the defence member or veteran transitioned from the ADF or transitioned between service categories; • the availability, accessibility, timeliness and quality of health, wellbeing and

[1] Australian Department of Health (2021), *What Primary Health Networks are*, <https://www.health.gov.au/initiatives-and-programs/phn/what-phns-are>
[2] Australian Department of Health (2021), *What Primary Health Networks do*, <https://www.health.gov.au/initiatives-and-programs/phn/what-phns-do>

Section/s Terms of Reference	
	support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services; • the manner and extent to which information about the defence member or veteran is held by and shared within and between different government entities; • the reporting and recording of information, relevant to the mental and physical health of defence members and veterans, at enlistment and during and after service;
3.1	The impact of culture within the ADF, the Department of Defence and the Department of Veterans' Affairs on defence members' and veterans' physical and mental wellbeing;
4.1, 4,2	The role of non-government organisations, including ex-service organisations, in providing relevant services and support for defence members, veterans, their families and others;

A US study highlighted that approximately half of ex-serving members who die by suicide visit a primary health care setting in the month before their death.[3] The same study suggested that ex-serving members are more likely to use a primary health care setting for mental health needs, rather than more specialised mental health services. In Australia, the Department of Veterans' Affairs (DVA) funds treatment of mental health and substance use disorders after diagnosis by a General Practitioner (GP), meaning that primary health care plays a significant role as a first point of contact for ex-serving ADF members.

This submission refers to 'ex-serving ADF members' throughout, defined as those who have served in the ADF at any point in their life for any period of time. This term is used as opposed to 'veterans' which can imply serving for a longer period of time. This selection was made to ensure inclusivity following consultation feedback from stakeholders.

In many instances the recommendations of this submission are also applicable to the families and children of these individuals. PHNs recognise the importance of also supporting families of ex-serving ADF members, as they are the main source of support for them.[4] This submission also acknowledges the spectrum of experiences and backgrounds within the cohort of ex-serving ADF members, including experiences that may have physical, psychological, social and economic impacts.

[3] Dobscha, S., Clark, K., Newell, S., Kenyon, E., Karras, E., Simonetti, J. and Gerrity, M., Strategies for Discussing Firearms Storage Safety in Primary health care: Veteran Perspectives, *Journal of General Internal Medicine*, June 2021, 36 (6), pp 1492 - 1502.
[4] Muir, S., Family Wellbeing Study Part 2: Military family approaches to managing transition to civilian life, *Australian Institute of Family Studies*, October 2018, <https://aifs.gov.au/publications/family-wellbeing-study-part-2-military-family-approaches-managing-transition>

1.2 Risk factors for suicide among ex-serving ADF members

Between 1 January 2001 and 31 December 2019, there were 1,273 deaths by suicide among members who had served at least one day of service with the ADF since 1985.[5] Compared to the general population, suicide rates[6] were lower for permanently serving males and reserve males, but higher for ex-serving males and females. This indicates that permanent and reserve service could act as a protective factor against suicide for some individuals, and that the risk increases after transition to civilian life. This is significantly more pronounced for females, with risk more than double their ex-serving ADF male counterparts.

The risk factors for suicide in ex-serving ADF members are multifaceted.[7] Based on a literature review conducted by Hunter New England Central Coast (HNECC) PHN and supplementary desktop research and consultation, these risk factors include:

- Involuntary separation from service: Members who separate from service voluntarily have lower rates of suicide, compared to members who separate involuntarily (over three times more likely).[8] Consultations have identified that involuntary separation can correspond to a lack of adequate time to prepare for civilian life, including seeking employment or education.
- Transition from service: Ex-serving ADF members have a higher likelihood of death by suicide compared to current serving ADF members.[9]
- Length of service: Increased risk has been identified in ex-serving ADF members with less than 12 months of service, compared to those with 10 years or longer of service history.[10]
- Presence of mental illness: Research shows that there is a higher lifetime incidence of mental health conditions for ex-serving ADF members, which correlates to increased risk factors for suicide ideation, suicide attempts and suicide.[11] Notably, rates of Post-traumatic Stress Disorder (PTSD) among ex-serving ADF members are nearly double compared to serving members, and significantly higher than the general community.[12] Further, there is a 54% lifetime likelihood for ex-serving ADF to experience anxiety, depression, and/or a drug or alcohol disorder at some point.[13]
- Lower levels of engagement with the health care system: A range of known factors impact ex-serving ADF member's engagement with the health system, and consequently their ability to seek help, an important factor in reducing rates of suicide.[14] Whilst there are

[5] Australian Institute of Health and Welfare (2021), Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 2001 to 2019. Cat. no. PHE 290. Canberra: AIHW, p 7.
[6] Ibid.,p 9.
[7] The Senate Foreign Affairs Defence and Trade References Committee (2017), The Constant Battle: Suicide by Veterans, *Defence and Trade References Committee inquiry into Suicide by Veterans and Ex-Service Personnel*, Canberra; Australia.
[8] Australian Institute of Health and Welfare (2021), Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 2001 to 2019. Cat. no. PHE 290. Canberra: AIHW, p 6.
[9] Jones, K., Varker, T., Stone, C., Agathos, J., O'Donnell, M., Forbes, D., Lawrence-Wood, E. & Sadler, N. (2020). Defence Force and Veteran suicides: Literature review. Report prepared for the Australian Commission on Safety and Quality in Health Care. Phoenix Australia – Centre for Posttraumatic Mental Health: Melbourne.
[10] Sadler, N., Van Hooff, M., Bryant, R., Lawrence-Wood, E., Baur, J., McFarlane, A., Suicide and suicidality in contemporary serving and ex-serving Australian Defence Force personnel, *Australian & New Zealand Journal of Psychiatry*, 2021, 55(5), pp 463–475.
[11] Jones, K., Varker, T., Stone, C., Agathos, J., O'Donnell, M., Forbes, D., Lawrence-Wood, E. & Sadler, N., Defence Force and Veteran suicides: Literature review, *Phoenix Australia – Centre for Posttraumatic Mental Health*, 2020, Melbourne.
[12] Department of Defence 2018. Transition and Wellbeing Research Programme. Mental Health and Wellbeing Transition Study. Mental Health Prevalence and Pathways to Care.
[13] Department of Veterans Affairs 2018. Mental Health and Wellbeing Study: Mental Health Prevalence.
[14] Calear AL., Batterham PJ., Christensen H., Predictors of help-seeking for suicidal ideation in the community: risks and opportunities for public suicide prevention campaigns, *Psychiatry Research*, 2014 Nov, 30;219(3), pp 525-530.

early signs that more people are seeking support in the preventative phase,[15] a range of challenges remain for ex-serving ADF members, including:

1. Limited understanding of mental ill-health and/or perceiving stigma related to mental ill-health and initiating help-seeking behaviour
2. Limited understanding of how to navigate the civilian health care system, and
3. Appropriateness and availability of services and care that understand and acknowledge ex-serving ADF member context and culture.

The design and delivery of mental health services, particularly in the primary and community health care sector, will need to consider and address the above risk factors. A DVA report identified that 43% of transitioned ADF members participating in the study accessed DVA funded treatment through a Veteran healthcare card. However, the majority of these people had someone else suggesting that they seek assistance, with partners being most likely (68.6%), but also general practitioners (31.1%) and medical officers (25.3%)[16]. Therefore, there is an opportunity for PHNs to reduce the impact of these risk factors to prevent suicide by facilitating increased engagement with the health system through their role in primary health care.

[15] Curtis, Katina., Veterans' suicide rate yet to fall but signs early intervention on right track, *The Sydney Morning Herald,* September 2021 <https://www.smh.com.au/politics/federal/veterans-suicide-rate-yet-to-fall-but-signs-early-intervention-on-right-track-20210928-p58vc9.html>
[16] Department of Veteran Affairs (2018), Pathways to Care, accessed < https://www.dva.gov.au/sites/default/files/files/health%20and%20wellbeing/research_dev/socialresearch/TWRP-Pathways-to-care-report.PDF>

2. Recommendations for the role of primary health care in supporting ex-serving ADF members

There are six key recommendations for PHNs to better support ex-serving ADF members. These have been developed as a result of comprehensive consultation across PHNs and are endorsed by the PHN Cooperative. Each recommendation has associated action items to be implemented across the short, medium, long and ongoing term. Further detail on each recommendation is provided in Section 5.

Each recommendation also identifies whether the activity would be primarily led by the Primary Health Networks or driven by primary health care providers.

Table 1: Summary of key recommendations for the role of primary health care in supporting ex-serving ADF members (definition of stakeholders contained in Section 1.1)

Recommendation	Potential role for Primary Health Networks	Timeframe[17]
Build greater recognition of the role that primary health care can play in supporting ex-serving ADF members	1.1 Collaborate with DVA, DoH and other relevant stakeholders to define the role of primary health care practitioners and providers in the delivery of relevant health services for ex-serving ADF members 1.2 Establish regular engagement mechanisms with DVA to develop, refine and better coordinate service availability and gaps 1.3 Develop a primary health care communication campaign for serving and ex-serving ADF members to increase service awareness and health literacy	Ongoing
Undertake joint localised regional service planning and commissioning between DVA and the primary health care sector	2.1 Take a place-based approach to reviewing the availability of existing mental health services to determine baseline service level, including access and maintenance of ex-serving ADF member data and clinical allied health questionnaires 2.2 Include an ex-serving ADF member view of health needs as part of annual regional services planning, leveraging census and other available data 2.3 Commission services, through coordination with DVA, to address areas of unmet need for ex-serving ADF members	Short to medium term
Provide advice and guidance for primary health care providers to recognise and support ex-serving ADF members, including	3.1 Develop national training and resources for primary health care providers, including specific guidance around cultural awareness, referral pathways and to identify appropriate services 3.2 Engage with general practice, other primary health care providers and DVA in addition to existing	Medium term

[17] Timeframe definitions are as follows: Short term = up to one year, Medium term = up to three years, Long term = up to five years

Recommendation	Potential role for Primary Health Networks	Timeframe[17]
provider education and specific referral pathways	bodies including the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), First Nations organisations (including but not limited to Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs)), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian Health Practitioner Regulation Agency (AHPRA; only if appropriate), and the Australian Medical Association (AMA; only if appropriate) to support the delivery of appropriate services for ex-serving ADF members[18] 3.3 Identify, establish and maintain a database of primary health care providers with experience in providing safe and accessible care to serving and ex-serving ADF members	
Co-design a consumer-centred stepped care model, leveraging off the existing approach, with relevant stakeholders	4.1 Co-design a stepped care model, leveraging off the existing approach and upcoming engagement (i.e., for Health Pathways), with consumers and other relevant stakeholders, including service providers, health care practitioners and clinicians, peak bodies and Returned Services Leagues (RSLs) 4.2 Design improved care navigation services to increase awareness of and access to available services	Medium term
Develop flexible workforce strategies to enable alternative workforce models	5.1 Develop flexible workforce strategies for the delivery of mental health services, including enabling the delivery of peer and community services for current and ex-serving ADF members, taking into consideration the contextual factors that influence workforce in regional and remote areas	Long term
Secure additional ongoing funding and resources for mental health and suicide prevention services for serving and ex-serving ADF members	6.1 Develop an implementation plan for recommended actions across PHNs based on agreed common principles, including identification of resources required and risk management processes 6.2 Develop associated investment plan to set out ongoing funding and resource requirements in the short, medium and long term	Short term

[18] This list of stakeholders is not exhaustive and will be refined during implementation planning.

3. The impacts of military service on engagement with the health system

Military service can have varied health and wellbeing impacts on an individual and can also change how individuals engage with the health system. Figure 1 below summarises the three key impacts from a primary health care perspective, based on insights gleaned through stakeholder consultation and surveys submitted.

Figure 1: Impacts of military service on engagement with the health system[19]

3.1 Limited understanding of mental ill-health and/or perceived stigma related to mental ill-health

A key finding from consultations with ex-serving ADF members is that there is an overall lack of understanding of the stigma associated with mental health conditions during and post-service.[20] This can lead to trivialisation or misunderstanding about the manifestation and impact of ill mental health. Further, consultations with ex-serving ADF members highlighted that certain

19 Developed based on insights from stakeholder consultation.

[20] Hodson, S. & McFarlane, A., Australia veterans - Identification of mental health issues, Australian Family Physician, March 2016, 45 (3).

periods during service were retrospectively considered to be significant triggers for worsening mental health.

Contributing factors

A number of factors were noted to explain the reasons behind a lack of understanding and acceptance of mental health, including:

- a culture within the ADF that promotes values of stoicism, soldier mentality and team over individual, impacting how traumatic experiences and mental health issues are handled
- unhealthy coping mechanisms, particularly alcohol abuse, is relatively common and socially acceptable
- a perceived lack of awareness and formal training about mental health, psychoeducation and available psychological support during time in service.

These factors are likely to all contribute to the stigma associated with accessing mental health services, making it less likely for an ex-serving ADF member to proactively seek help post-transition.

Impact

This lack of understanding around mental health and the support services available creates a significant barrier to ex-serving ADF members accessing the support they need, when they need it. This can lead to both detrimental short- and long-term impacts on the individual and their families as untreated mental health issues can increase in severity, potentially leading to suicide, attempted suicide or suicide ideation.[21]

3.2 Limited understanding of how to navigate the civilian health care system

The military health system is separate from the civilian health care system, meaning that often ex-serving ADF members have not had the opportunity to build and maintain relationships with primary health care practitioners and GPs. Stakeholders also noted that in general, there is a tendency for ex-serving ADF members to feel 'estranged' when attempting to access civilian services. This, in addition to navigating an already complicated health care system, results in ex-serving ADF members facing additional difficulties.

Contributing factors

Consultation insights and studies have identified a number of factors that contribute to difficulties that an ex-serving ADF member may have in navigating the civilian health care system, including:

- Lack of experience with Medicare and mainstream health system, due to entering the ADF during formative years of their lives (e.g., 15-18 years old).[22] This means that prior to joining the ADF, many people have limited experience in accessing support in the mainstream health system, particularly without the help of family, and may face difficulties with obtaining Veteran healthcare cards and Medicare cards. Ex-serving ADF members are therefore less likely to have a long-term relationship with a GP, who plays a critical role in

[21] Open Arms (2011), Mental Health and Wellbeing after Military Service, Australian Centre for Posttraumatic Mental Health <https://www.openarms.gov.au/sites/default/files/2020-02/mental_health_and_wellbeing_booklet_2011_0.pdf>

[22] There is no publicly available data on the average age of service admission of ex-serving ADF members who have committed suicide. The median age at death for ADF members who died by suicide between 2001 and 2018 (34 for males and 32 for females) was younger than for those who died by suicide in the Australian population (43 for males and 44 for females).

providing information and referrals onto other specialised services if required, including psychologists and psychiatrists. Consultations also highlighted that the availability of services is often established through peers or friends.

- Inadequate support during transitioning out of the ADF, particularly in preparing to navigate the civilian health care system and establishing relationships with primary health care providers.
- Timeframes of discharges, particularly in the short term after the discharge can also impact level of health system navigation. Medical discharges in particular, can be abrupt and provide inadequate time for planning to adapt to civilian life, further complicating the ability to transition successfully.
- Distrust in the health system due to the lack of prior engagement with it, particularly as an adult. This is due to entry into the military health system, often from a young age, and relating to the general stigma with accessing mental health services in the ADF.
- Difficulty accessing services through DVA, due to the administrative burden and lengthy processing times. For example, a case study provided by Brisbane North PHN identifies politics and complexities around access to Veteran healthcare cards and restrictions around contacting treating health providers on behalf of clients.

Impact

The inability to navigate the civilian health care system can result in low engagement with primary health care services, perpetuating low levels of health literacy and furthering the impacts of undiagnosed or untreated mental health conditions that can escalate. Peripherally, this can also worsen feelings of isolation that can be experienced by ex-serving ADF members who do not have a strong support network upon transitioning to civilian life. Literature has also shown that primary health care services can play a significant role in identifying suicide risks early,[23] therefore this lack of engagement limits opportunities for early intervention and prevention of suicide risks. This is particularly critical during the first three years after transition, the period where the risks of suicidality are highest, and where early intervention in primary health care may be achieved through screening and provision of records.[24]

3.3 Appropriateness and availability of services and care that understand and acknowledge ex-serving ADF member context and culture

In a submission to the Defence and Trade References Committee inquiry into Suicide (2017), the Australian Institute for Suicide Research and Prevention (AISRP) commented that mental health clinicians are reluctant to work with ex-serving ADF members because they feel under skilled to effectively support them.[25] Further, consultations and surveys undertaken for the development of this submission found that ex-serving ADF members lack access to appropriate support services that are sensitive to ex-serving ADF member specific needs. Currently, training is provided through the RACGP to offer advice to GPs on military culture and on delivering evidence-based treatments for the ex-serving ADF cohort. The Veteran Mental Health GP Assistance Hotline also provides GPs with access to a multi-disciplinary team of mental health

[23] Dobscha, S., Clark, K., Newell, S., Kenyon, E., Karras, E., Simonetti, J. and Gerrity, M., Strategies for Discussing Firearms Storage Safety in Primary health care: Veteran Perspectives, Journal of General Internal Medicine, June 2021, 36 (6), pp 1492 - 1502.
[24] Jones, K., Varker, T., Stone, C., Agathos, J., O'Donnell, M., Forbes, D., Lawrence-Wood, E. & Sadler, N., Defence Force and Veteran suicides: Literature review, Phoenix Australia – Centre for Posttraumatic Mental Health, 2020, Melbourne.
[25] The Senate Foreign Affairs Defence and Trade References Committee (2017), The Constant Battle: Suicide by Veterans, *Defence and Trade References Committee inquiry into Suicide by Veterans and Ex-Service Personnel*, Canberra; Australia.

experts[26] who provide consultation on mental health and trauma in relation to ex-serving ADF members.

While training is available, there is no requirement for clinicians to complete it. There is also limited transparency for ex-serving ADF members to identify clinicians that have chosen undertaken this training.[27] In addition, when ex-serving ADF members do seek to access mental health services through DVA, there is significant bureaucratic red tape associated. An example is the high backlog of claims held by DVA, which is delaying ex-serving ADF members from accessing the services they need.[28]

Contributing factors

The civilian health care system is complex, and services are often poorly coordinated. Consultations and literature have identified a number of factors that contribute to an inability to access appropriate services and care:

- There is a perception that civilian clinicians lack understanding or necessary experience to provide appropriate care as ADF members and ex-serving ADF members have very different lived experiences compared to the general population
- Lack of tailored services that are suitable for the individual mental health needs for an ex-serving ADF member
- There is limited capability to easily identify suitable general practitioners with a background or interest in military health
- Availability of appropriate services is more likely to exist in Garrison Towns where there are a higher population of ex-serving ADF members[29]
- Resourcing and capacity constraints related to accessing qualified care providers and clinicians.[30]

Another relevant issue is the general lack of data associated with ex-serving ADF attendance at primary health care settings. This is because individuals are not required to identify as an ex-serving ADF member when accessing general practices or other primary health care services. Further, this information is not a part of mandatory data collection and may also be limited by hesitancy to share on the part of the ex-serving ADF member.

Impact

As a result, ex-serving ADF members may not be able to access appropriate services and care, particularly in a community setting. Further, some ex-serving ADF members may be accessing primary health care services but due to data limitations they are unable to be identified. This lack of health information data for ex-serving ADF members also means that there is limited visibility in identifying risk factors for suicide early. Moreover, due to a lack of perceived specialised and experienced workforce in this area, individuals transitioning from the ADF are less likely to approach services in the short to medium term following service.

[26] Department of Veterans' Affairs. (2020). New veteran mental health assistance line. <https://www.dva.gov.au/providers/provider-news/new-veteran-mental-health-assistance-line>
[27] PHN Literature Review (DVA 2021).
[28] Minister for Veterans' Affairs (2021), Veterans claims system to be overhauled <https://minister.dva.gov.au/news-and-media/veterans-claims-system-be-overhauled>
[29] Identified in consultation with PHNs.
[30] Consultation with stakeholders.

3.4 Cultural and other considerations and impacts

First Nations ex-serving members

In comparison to the general population, First Nations peoples are at higher risk of dying by suicide.[31] This means that First Nations ex-serving ADF members have significantly higher risk factors of suicide compared to the general population. While specific statistics for this cohort are not known,[32] consultations identified a number of barriers specifically faced upon returning to civilian life from service. These include a loss of connection to culture, community and Country, and a lack of available culturally appropriate and safe health and social services.

There has been an increase in the proportion of First Nations ADF members, with census data identifying an increase from 2.3% in 2015 to 3.7% in 2019. This increase indicates future growth in the cohort of ex-serving First Nations ADF members. Considerations for culturally appropriate services should be cognizant of the culture, community and identity shift that may occur as a result of serving. Some examples of this highlighted from consultations and literature review include:

- First Nations people may feel pressured or required to conform during time in service, and may consequently feel disconnection from their culture, Country and community upon transition out of the ADF
- There is a lack of cultural safety in the ADF, stemming from pressure to conform to military culture rather than cultural differences being recognised and respected
- There are a range of long-term intergenerational impacts of service, including removal of First Nations people from Country and not being afforded the opportunity to be a part of 'Soldier Settlement' land grant schemes
- First Nations people may experience subtle and overt racism during their time in service[33]
- The lack of recognition of contemporary and historical First Nations contributions to the ADF compared to other service people[34]
- The impact of returning from service to be confronted with the forced removal of family members whilst serving.

There are over 140 Aboriginal Community Controlled Health Services (ACCHSs) in Australia. However, there are none that focus specifically on ex-serving ADF support or intervention. In order to provide culturally appropriate care for First Nations ex-serving ADF members, it is important that mental health practitioners and providers are culturally competent and aware. This may involve the provision of training focussed on the First Nations service experience, and implications for specific mental health and care needs.

Female ex-serving members

Existing services available for ex-serving ADF members are primarily targeted at male consumers. A study conducted in 2012[35] found that female ex-serving ADF members were

[31] Australian Institute of Health and Welfare, Deaths by suicide amongst Indigenous Australians <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/suicide-indigenous-australians>
[32] SBS (2020), 'We've got to do it properly': Indigenous veteran worried about suicide inquiry, <https://www.sbs.com.au/nitv/article/2020/02/06/weve-got-do-it-properly-indigenous-veteran-worried-about-suicide-inquiry>
[33] City of Sydney Oral History Program, Aboriginal and Torres Strait Islander Service Men and Women, accessed: https://s3-ap-southeast-2.amazonaws.com/cdn.sydneyoralhistories.com.au/wp-content/uploads/Williams-David.pdf
[34] City of Sydney Oral History Program, Aboriginal and Torres Strait Islander Service Men and Women, accessed:https://s3-ap-southeast-2.amazonaws.com/cdn.sydneyoralhistories.com.au/wp-content/uploads/Albert-Tony-.pdf
[35] Samantha Crompvoet (2012), accessed: dva.gov.au/sites/default/files/2021-09/viet_fem_con_report.pdf

impacted by barriers to accessing appropriate services, with interventions not appropriately understanding or addressing the needs of female ex-serving members. This includes a lack of compatibility with carer responsibilities which primarily affect females. Statistics at the time of the study showed approximately 75 reported cases of sexual abuse or harassment in the ADF each year, and anecdotal reports of regular occasional harassment (such as name calling and derogatory remarks). The planning and design of future mental health services needs to consider the unique experience and needs of female ex-serving members.

LGBTIQ+ ex-serving members

The ADF has a history of prejudice and discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) serving members, including formal policies and bans, as well as discriminatory practices in service. This has included traumatic investigation processes, surveillance and intimate questioning[36]. Until 2005, same sex partners were not recognised by the ADF. As such, those ex-serving ADF individuals and families serving or discharged during earlier periods may still suffer on going mental health issues. More broadly, LGBTI people and communities require access to appropriate health services, including services that are safe and respectful as well as meeting the particular health needs of this cohort. Planning and design of mental health services for ex-serving ADF members needs to consider the unique health requirements and service experience of LGBTI ex-serving members.

[36] Australian Policy and History (2018), Historic LGBT Discharges: Apologies and redress, accessed: https://aph.org.au/2018/09/historic-lgbt-discharges-apology-and-redress/

4. Demonstrated impact of primary health care interventions

Primary health care interventions have had a successful demonstrated impact for improving mental health outcomes. This includes interventions targeted at serving and ex-serving ADF members, in addition to interventions targeting other population cohorts.

Among interventions for ex-serving ADF members, there have been several services and programs that have achieved positive outcomes in improving the transition into civilian life, including regarding mental health and wellbeing. Success factors of these interventions include:

1. **Using evidence to inform program design –** employing methodologies in programs and activities that have demonstrated effectiveness in improving outcomes.
2. **Employing components of a stepped care approach –** designing programs where service levels are tailored to an individual's treatment need.
3. **Providing care coordination support –** focusing on how an individual navigates a range of services available to them, ensuring integration across services and effective transitions.
4. **Using peer and community support models –** employing peer and psychosocial approaches to care to enable a holistic and localised approach to care.

In addition to programs targeting serving and ex-serving ADF members, broader examples highlight the impact of primary health care interventions in delivering positive mental health outcomes for Australians. These include innovative models such as stepped care, social prescribing, digital, and peer support. Lessons from these models can be considered in the design of services for ex-serving ADF members. Success factors of other services have included:

1. **Tailored and individualised care –** providing services that are specific to an individual or cohort to ensure greatest effectiveness.
2. **Holistic and integrated services –** employing supplementary approaches to traditional care and facilitating seamless transition between services.
3. **Digitally enabled, accessible care options –** incorporating elements of digital health technologies into care to increase access, reduce cost and enable self-management where appropriate.

Further detail on both targeted interventions and broader primary health care interventions can be found in Appendix 4. Table 2 below maps current primary health care interventions to the potential future role of primary health care in supporting ex-serving ADF members. Note that this list of services is by no means comprehensive and/or exhaustive but demonstrates primary health interventions (bespoke and mainstream) that are already available to ex-serving ADF members and their families.

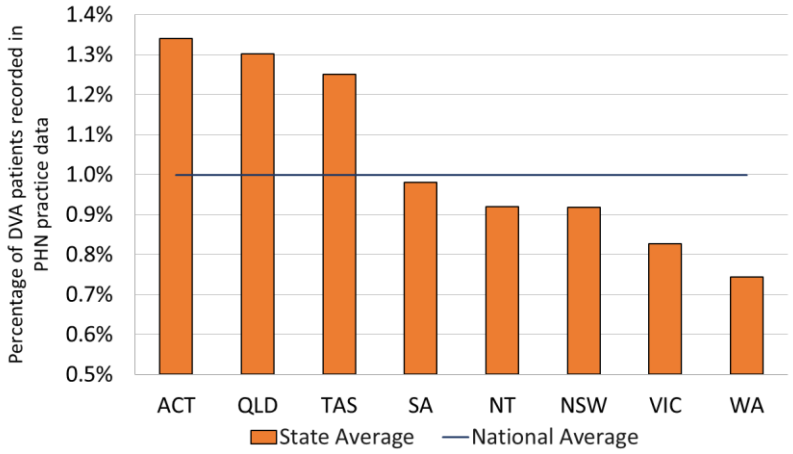
Table 2: Current primary health care interventions mapped against the future role of primary health care

	Role of primary health care in supporting ex-serving ADF in the future			
	Localised planning and commissioning	**Advice and guidance to primary health care**	**Consumer-centred stepped care model**	**Flexibility in delivery, enabling alternative workforces**
Primary health care interventions for ex-serving ADF members				
Operation Compass (Northern Queensland PHN)	✓	✓	✓	
GP education to better support ex-serving ADF members		✓		
Health Pathways (30 of 31 PHNs)	✓	✓		
Defence NewAccess program				✓
InnoWell platform			✓	
Team Care Coordination (TCC) (Brisbane North PHN)	✓	✓		✓
Open Arms Veterans & Families Counselling				✓
Axis Clinic (Brisbane North PHN)	✓			✓
Mates4Mates	✓			✓
Broader primary health care interventions for mental health				
Right Care = Better Health Service (Eastern Melbourne PHN)	✓			✓
The Way Back Support Service (TWB) (Australian Capital Territory PHN)	✓		✓	
The Care Navigation pilot projects (HNECC PHN)	✓	✓	✓	
Headspace Centres	✓			
Our Ways to Wellness	✓			✓

5. Future opportunities for the primary health care sector in supporting ex-serving ADF members

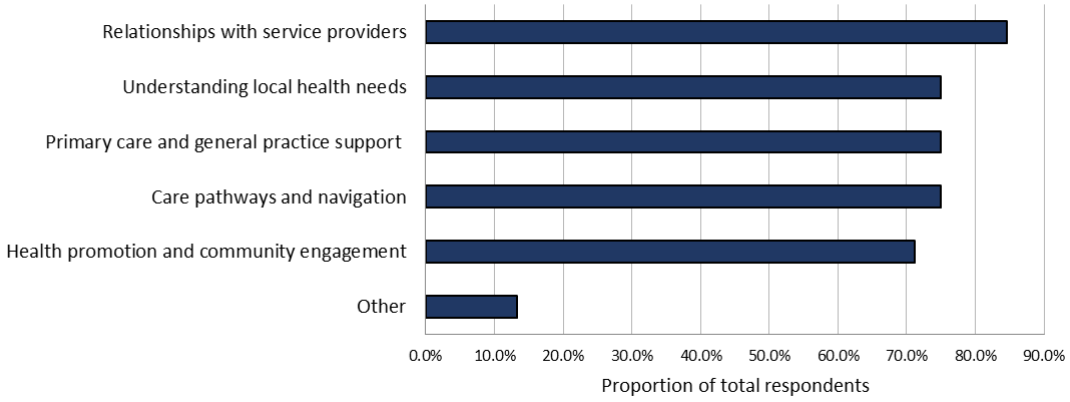
There are a range of limitations in the data collected due to ex-serving ADF members not being required to identify as such, and not all PHNs providing data. In 2018, DVA estimated that there were 641,000 living ex-serving ADF members - accounting for approximately 2.6%[37] of the population. Nationwide, an average of 1% of total patients in a primary health care setting were identified and recorded as being an ex-serving ADF member, through their affiliation with DVA.[38] As shown in Figure 2, the ACT, Queensland and Tasmania have the highest state-based average of ex-serving ADF members accessing and recording their DVA status in primary health care, above the national average.

Figure 2: Percentage of DVA patients recorded in PHN practice data (as of June 2021)



Through stakeholder consultation, a range of opportunities for the primary health care sector to better support ex-serving ADF members were identified. PHN survey respondents[39] noted several areas where PHNs could bring a range of strengths and strategic value to support ADF and ex-serving ADF members, as summarised in Figure 3.

Figure 3: Strengths and strategic value of PHNs in supporting ADF and ex-serving ADF members



[37] 24.98 million population in Australia (World Bank).
[38] Appendix 3 tables the data of ex-serving ADF representation in accessing primary health care through GPs by state. This data has been provided across 24 of the 31 PHNs.
[39] Including PHN CEOs, Board Members, members of Clinical Council and Community Advisory Committees.

Further, 70% of PHN survey respondents noted that existing programs and services had been largely well received by serving and ex-serving ADF members. To build on the value and potential of PHNs in supporting ex-serving ADF members, a range of opportunities were identified for PHNs to play a more impactful role for serving and ex-serving ADF members, including:

- Supporting general practice and other service providers (79% of respondents) to work with ADF members and ex-serving ADF members
- Developing care pathways (75% of respondents)
- Commissioning mental health services (69% of respondents)
- Increasing health literacy and engagement with services through health promotion (65% of respondents).

Based on these findings and insights, there are a set of six recommendations to leverage and realise the potential of PHNs and primary health care in supporting ex-serving ADF members, detailed below. Accompanying actions for each recommendation are also detailed, with responsible stakeholders identified.

Recommendation 1. Build greater recognition of the role that primary health care can play in supporting ex-serving ADF members

Greater recognition of the role that primary health care can play is required for PHNs to proactively act to better support ex-serving ADF members. Collaboration between PHNs, DVA and DoH will be central to achieving this.

This submission recognises the clear role that primary health care can play in supporting ex-serving ADF members in the community once they have transitioned from service. This is demonstrated through the success of existing targeted programs and mainstream mental health services in the community. Consultations have identified that many, particularly younger, ex-serving ADF members experience hesitancy with accessing services associated with DVA and use services provided by organisations such as Open Arms. The primary health care setting is therefore an important opportunity for prevention, early intervention and suicide risk assessment. For example, primary health care could increase targeted interventions for individuals who are medically discharged from the ADF.

This is also supported by literature as studies have shown that half of ex-serving ADF members have visited a primary health care setting in the month prior to their death by suicide, meaning health care practitioners in a primary health care setting could play a critical role in the screening process.[40] This emphasises the requirement that where comorbid issues or physical health consultation or screening is occurring, that a holistic approach be taken to care to prevent and address other underlying concerns or mental illnesses that may be present.

In order for PHNs to act upon these findings, there is a need for greater widespread recognition of the importance of primary health care so that ex-serving ADF members are aware of and comfortable to approach this form of care. Collaboration between PHNs, DVA and the DoH will be required to comprehensively define the role of primary health care into the future to support ex-serving ADF members in addition to better coordinating services. When service levels and the role of primary health care has been defined, a communication campaign for ex-serving ADF members should be developed, focused on increasing awareness and literacy.

[40] Dobscha, S., Clark, K., Newell, S., Kenyon, E., Karras, E., Simonetti, J. and Gerrity, M., Strategies for Discussing Firearms Storage Safety in Primary health care: Veteran Perspectives, Journal of General Internal Medicine, June 2021, 36 (6), pp 1492 - 1502.

Further, there is an opportunity for these conversations regarding support following service to begin while an individual is still serving, to prepare both mentally and logistically for transition and life after service.

1.1 Collaborate with DVA, DoH and other relevant stakeholders to define the role of primary health care providers and practitioners in the delivery of health care services for ex-serving ADF members (Primary Health Networks)

1.2 Establish regular engagement mechanisms with DVA to develop, refine and better coordinate service availability and gaps (Primary Health Networks)

1.3 Develop a primary health care communication campaign for serving and ex-serving ADF members to increase service awareness and health literacy (Primary Health Networks)

Recommendation 2. Undertake joint localised regional service planning and commissioning between DVA and the primary health care sector

There is a need to better understand the gaps in mental health services already available to ex-serving ADF members within individual regions in Australia and target these gaps through joint regional service planning and commissioning.

Reviewing existing service levels is critical to enable a better understanding of the availability of health care services for ex-serving ADF members in the community, and consideration of their effectiveness and appropriateness. This will include consideration of services available through DVA and within the community and primary health care sector and enable identification of where service gaps exist at a regional level. Taking a place-based approach will enable the development of a detailed understanding of services available at a local level, including identifying opportunities to bring different services and organisations together to maximise the availability of services for ex-serving ADF members. This includes considering the presence and role of voluntary organisations in receipt of DVA funding (such as Returned Services Leagues) with the potential to provide lived experience and peer worker connections to support awareness and destigmatisation.

Joint regional service planning also includes considering opportunities for greater integration between primary and acute settings of care in accordance with the Needs Assessment Policy Guide and the Mental Health Regional Plan 2020-2025 incorporating Suicide Prevention. Integration is critical within a stepped care model to enable escalation and transfer of care between hospitals and primary health care. This should include the use of early identifiers for PHNs to provide services for ex-serving ADF members who are identified as high risk.

There is an opportunity for joint regional service planning to review service gaps and plan for appropriate interventions to meet the needs of ex-serving populations at a local level. Joint localised regional service planning should also consider:

- Demand for services at a local level
- The current state of support services available to reservists and families of ex-serving ADF members
- Cultural appropriateness of existing services, particularly for First Nations peoples
- Support services available for bereaved families of ADF members or ex-serving ADF members who have been lost to suicide
- Opportunities for existing services to be tailored for the needs of ex-serving ADF members.

Based on the results of this needs-based assessment, there may be an opportunity for PHNs, in collaboration with DVA, to commission additional services for ex-serving ADF members,

including tailoring existing primary health care services for the cohort. Taking a PHN-led commissioning approach will ensure that resources and funding can be maximised for impact at a localised level. This will also leverage existing PHN efforts to strengthen system integration between acute and primary health care settings at a regional level.

2.1 Take a place-based approach to reviewing the availability of existing mental health services to determine baseline service level, including access and maintenance of ex-serving ADF member data and clinical allied health questionnaires (Primary Health Networks)

2.2 Include an ex-serving ADF member view of health needs as part of annual regional services planning, leveraging census and other available data (Primary Health Networks)

2.3 Commission services, through coordination with DVA, to address areas of unmet need for ex-serving ADF members (Primary Health Networks)

Recommendation 3. Provide advice and guidance for primary health care providers to recognise and support ex-serving ADF members, including provider education and specific referral pathways

There is an opportunity for primary health care providers, including GPs and allied health practitioners, to be upskilled to identify the risk factors for suicide in ex-serving ADF members. This will help ensure they are informed of localised care options and referral pathways appropriate to ex-serving ADF members with differing intensities of health care needs.

When accessing a primary health care setting, many ex-serving ADF members may not identify as such and consequently may not be recognised. Therefore, primary health care providers and particularly GPs need to be enabled to proactively identify and support ex-serving ADF members as a critical step for early prevention in suicide.

GPs also play a crucial role in providing referrals onto other services, so they must be able to effectively triage the needs of an individual to provide suitable and appropriate referrals onto other mental health services. This should also include awareness and promotion of existing available services. Under the PHN guidance for stepped care, it is expected that most mental health services commissioned by PHNs (except for low intensity mental health services) will require a referral from a GP.[41] Therefore, a GP's understanding of referral pathways and the identification of appropriate services and support for ex-serving ADF members is critical.

Reviewing referral pathways should leverage existing resources (such as Healthdirect) which may be expanded to better support centralised triage and referral pathways. This may include developing specific referral pathways and triaging guidance for ex-serving ADF members.

The provision of advice and guidance for primary health care providers should be integrated with wider mental health reform, including around adopting trauma-informed models of care. Research has identified that certain groups experience higher incidences of trauma, including First Nations people and socially disadvantaged groups.[42] This is critical for the needs of ex-serving ADF members, who may have experiences of trauma that impact their mental health and wellbeing and their engagement with health services.

Additionally, consultations conducted in the development of this submission identified the potential need for a database that lists primary health care providers with an existing specific

[41] Australian Department of Health (2019), PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance, Australian Government Department of Health <https://www.health.gov.au/sites/default/files/documents/2021/04/primary-health-networks-phn-primary-mental-health-care-guidance-stepped-care.pdf>

[42] The Agency for Clinical Innovation (2019), Trauma-informed care and mental health in NSW, *Mental Health Network,* <https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0008/561977/ACI-Mental-Health-Trauma-informed-care-mental-health-NSW.pdf>

interest or expertise in working with ex-serving ADF members and their families. This information should be made accessible to ex-serving ADF members publicly to reduce reliance on word-of-mouth referrals that currently occur and to increase the level of comfort of ex-serving ADF members in approaching services.

3.1 Develop national training and resources for primary health care providers, including specific guidance around cultural awareness, referral pathways and to identify appropriate services (Primary Health Networks)

3.2 Engage with general practice, other primary health care providers and DVA in addition to existing bodies including the Royal Australian College of General Practitioners (RACGP), the Australian College of Rural and Remote Medicine (ACRRM), First Nations organisations (including but not limited to Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services (AMSs)), the Royal Australian and New Zealand College of Psychiatrists (RANZCP), the Australian Health Practitioner Regulation Agency (AHPRA; only if appropriate), and the Australian Medical Association (AMA; only if appropriate) to support the delivery of appropriate services for ex-serving ADF members[43] (Primary Health Networks)

3.3 Identify, establish and maintain a database of primary health care providers with experience in providing safe and accessible care to serving and ex-serving ADF members (Primary Health Networks)

Recommendation 4. Co-design a consumer-centred stepped care model, leveraging off the existing approach, with relevant stakeholders

Engagement with ex-serving ADF members and other stakeholders is crucial in designing a consumer-centred stepped care model that leverages lessons learned from existing initiatives and research to ensure cultural safety, tailored care and coordinated support.

Stepped care provision has already been successfully proven as a primary health care intervention for military mental health, through programs such as Defence New Access and the Open Arms InnoWell platform. A stepped care model enables greater focus on prevention and early intervention of mental health conditions, through consideration of their severity.

As part of adopting a stepped care approach, an outreach model, such as The Oasis established through Operation COMPASS, could be considered for future implementation. In 2019, the Remembrance Foundation commissioned an economic impact assessment of a Veteran Mental Health Outreach Model, compared to existing services. The findings from this assessment suggested that outreach components are expected to redistribute demand for services, step up or down depending on need, and generate cost savings through both direct and indirect means. Implementation of an outreach model could also see up to 31,000 ex-serving ADF members and 45,600 family members access mental health services annually.[44]

A consumer-centred approach should also include a focus on care navigation support. Ex-serving ADF members may experience greater difficulty in navigating the system to access the right services. Of service provider and practitioner survey respondents, 82% noted 'awareness of available services' as a key challenge for ex-serving ADF members in accessing services, with the same proportion of respondents attributing 'willingness to engage' as another barrier. As a result, there should be a renewed focus on care navigation support that is centred on

[43] This list of stakeholders is not exhaustive and will be refined during implementation planning.
[44] PwC (2019), Economic Impact Assessment of the Veteran Mental Health Outreach Model, Remembrance Foundation, p 6.

empowering and educating ex-serving ADF members to access and navigate the civilian health system. Incorporating elements of digital health technologies (i.e. telehealth, applications, self-monitoring devices) into care to increase access, reduce cost and enable self-management where appropriate should also be considered in the design of services into the future to complement care and empower ex-serving ADF members.

Engagement with ex-serving ADF members and other stakeholders will facilitate sharing of ex-serving ADF and their families lived experiences, which has been identified in consultations to be crucial to designing a model that works. Co-designing a stepped care model should also incorporate consideration of delivering culturally appropriate services, particularly for First Nations ex-serving ADF members. This would include the identification and engagement of relevant peak bodies, individuals and family members to act as 'champions' in supporting the co-design process.

PHNs are already seeking to engage ex-serving ADF members in the next phase of work for Health Pathways, where a plan for a clinical pathway with related referral pages will be developed. Ongoing engagement with ex-serving ADF members and identifying champions to support future primary health care interventions for military health is critical.

4.1 Co-design a stepped care model, leveraging off the existing approach and upcoming engagement (i.e. for Health Pathways), with consumers and other relevant stakeholders, including service providers, health care practitioners, clinicians, peak bodies and RSLs (Primary Health Networks)

4.2 Design improved care navigation services to increase awareness of and access to available (Primary health care providers and practitioners)

Recommendation 5. Develop flexible workforce strategies to enable alternative workforce models

Mental health services for ex-serving ADF members must be designed around a flexible and appropriately skilled workforce in a way that maximises access and availability.

Within the primary health care sector, PHNs and primary health care service providers play an important role in supporting ex-serving ADF members. Primary health care particularly must have the capability and capacity to identify chronic conditions, risk factors for suicide, referrals and ongoing management (if necessary).

Consultations with PHNs and general practitioners has pointed to the ongoing challenge of workforce availability in the mental health sector across Australia. The National Mental Health Workforce Strategy Consultation Draft released in August 2021 recognises that across all Australian States and Territories, the demand for mental health support and treatment has increased over time and outstrips supply.[45] This document points to a diverse range of factors that impact the lack of support and treatment available to people experiencing suicidality or ill mental health, but points to the lack of 'an appropriately skilled workforce' as a key reason.

In this context, there is a need to consider alternative workforce models that maximise the availability of mental health support services for ex-serving ADF members, and consider who may be best placed to deliver these services. This may include a greater focus on alternative workforces for lower intensity needs, such as community and peer support. Consultations have also identified the effectiveness of social prescribing as a form of support for those with lower

[45] Acil Allen (2021), National Mental Health Workforce Strategy, National Mental Health Workforce Taskforce <https://acilallen.com.au/uploads/media/NMHWS-ConsultationDraftStrategy-040821-1628234534.pdf>

intensity mental health needs. For example, exercise, through access to personal trainers, was identified as having a positive impact on mental health outcomes for ex-serving ADF members. Other community support programs that have worked well for ex-serving ADF members include Open Arms Veterans & Families Counselling and Mates4Mates.

5.1 Develop flexible workforce strategies for the delivery of mental health services, including enabling the delivery of peer and community services for current and ex-serving ADF members, taking into consideration the contextual factors that influence workforce in regional and remote areas (Primary health care providers and practitioners)

Recommendation 6. Secure additional ongoing funding and resources for mental health and suicide prevention services for serving and ex-serving ADF members

Ongoing funding and resources are required to enable the implementation of these recommended actions.

To realise the potential of PHNs and the primary health care sector to support ex-serving ADF members, there is a need for additional funding and resources to enable the implementation of the actions outlined in this submission. This is critical to enable joint regional service planning, support and education for primary health care providers, and the co-design of appropriate services and workforce models for ex-serving ADF members. It is important that ongoing funding decisions consider existing mental health funding and anticipated reforms or injections as an outcome from broader national mental health strategies. This will help to ensure value for money and ongoing alignment to wider reform initiatives.

Existing mechanisms for suicide prevention should be leveraged wherever possible when developing an implementation plan for suicide prevention services for serving and ex-serving ADF members. These may include:

- local peak bodies and other organisations
- existing infrastructure and resources
- lessons learnt from targeted programs to date.

PHNs will need to be appropriately resourced if they are to play a greater role in coordinating and commissioning support for this population cohort. This may involve establishing a dedicated liaison or coordinator role within PHNs and targeting additional resources to those PHNs with higher proportions of ex-serving ADF members in their population (particularly those with garrison towns within their region) to lead initiatives on behalf of the broader Primary Health Networks.

6.1 Develop implementation plan for recommended actions across PHNs based on agreed common principles, including identification of resources required and risk management processes (Primary Health Networks)

6.2 Develop a business case along with an associated investment plan to set out ongoing funding and resource requirements in the short, medium and long term (Primary Health Networks) to present to the Department of Health for consideration.

6. Appendices

Appendix 1: Process for development of submission

Hunter New England and Central Coast (HNECC) PHN led the development of this submission on behalf of the PHN Cooperative.

A broad range of stakeholders were consulted in developing this submission, including:

- Ex-serving ADF members
- PHN representatives
- Health and wellbeing practitioners and commissioned providers
- Hunter New England Central Coast PHN Working Group
- External Focus Group
- National Mental Health Alcohol and Other Drugs (NMHAOD) Working Group

Insights from these stakeholder groups were collected through one-to-one consultations (nine held with ex-serving ADF members), four Roundtables with PHN representatives, regular working group meetings and three surveys across various stakeholder groups, with a total of 75 responses. Further detail on the consultation approach and stakeholders consulted is contained in Appendix 2.

Information and findings from the consultation program was synthesised with the HNECC literature scan and supplementary desktop research into themes, outcomes and recommendations. These were tested and reviewed by the PHN Working Group, External Advisory Group and NMHAOD Working Group at regular intervals throughout the development period. PHN representatives and CEOs had opportunities to provide feedback to the submission via some face-to-face sessions and the survey, and opportunities to review and provide feedback to the draft submission.

Appendix 2: Stakeholder engagement

As part of the development of the submission, a range of stakeholder engagement activities were conducted and are summarised in the table below.

Table 1: Summary of stakeholder engagement

Group	Stakeholder	Engagement format	Engagement
Ex-serving ADF members	• Ex-serving ADF members	• One on one consultations *(including one female and one First Nations consultation)*	9 consultations
PHN representatives	• PHN CEOs • PHN Clinical and Community Council members • PHN staff, management and executives	• Online survey • Roundtables	52 survey responses; 4 roundtables
Health and wellbeing practitioners	• Individual general and mental health practitioners • Select Peak Body	• Online survey • Roundtable	8 survey responses; 1 roundtable
HNECC Working Group	• HNECC leadership and other representatives	• Meetings at key points of submission development	6 meetings
External Focus Group	• Representatives external to HNECC with ex-serving ADF experience	• Meetings at key points of submission development	3 meetings
Commissioned providers	• Psychosocial and specialist ex-serving ADF member support groups and providers	• Survey	15 survey responses
NMHAOD Working Group	• Representatives from PHNs	• Meetings at key points of submission development	2 meetings
Other	• Military personnel resilience researcher	• One on one consultation	1 consultation

Appendix 3: PHN DVA patient data

As part of the development of this submission, a data request of DVA patients' records attending general practices was sent out to 31 PHNs. Information was received from 25 PHNs (81 per cent response rate).

Table 2: DVA patients recorded in practice data by PHN

State	PHN Name	% of DVA patients recorded in practice data
QLD	Central Queensland, Wide Bay, Sunshine Coast	1.62%
QLD	Northern Queensland	1.56%
QLD	Darling Downs and West Moreton	1.47%
QLD	Brisbane North	1.47%
NSW	North Coast	1.41%
VIC	Gippsland	1.40%
ACT	Australian Capital Territory	1.34%
TAS	Tasmania	1.25%
SA	Country SA	1.18%
NSW	Murrumbidgee	1.13%
NSW	Hunter New England and Central Coast	1.10%
NT	Northern Territory	0.92%
NSW	Western NSW	0.86%
VIC	Western Victoria	0.84%
WA	Perth South	0.79%
SA	Adelaide	0.78%
WA	Country WA	0.78%
NSW	Central and Eastern Sydney	0.73%
NSW	Nepean Blue Mountains	0.70%
WA	Perth North	0.66%
VIC	North Western Melbourne	0.57%
NSW	Northern Sydney	0.50%
VIC	South Eastern Melbourne	0.50%
QLD	Western Queensland	0.39%

Appendix 4: Primary health care interventions

4.1 Primary health care interventions for ex-serving ADF members

Operation Compass (Northern Queensland PHN) is a Commonwealth trial run by North Queensland PHN and consists of six campaigns that were developed based on research conducted by The Black Dog Institute. This program aims to reduce rates of suicide and increase wellbeing within the ex-serving ADF community and their families, through supporting connection to life within a specific location. As part of this program, the ADF community and the general public were engaged in suicide prevention awareness programs.

GP education to better support ex-serving ADF members (HNECC PHN) includes developing awareness amongst general practitioners of common risk factors for ex-serving ADF member suicide, in combination with general population risk factors for suicide, to improve the effectiveness and outcomes of early screening. Evidence suggests that clinicians should ideally use a range of separate assessment tools to evaluate risk of suicide, drawing on both self-reported measures and observations from clinician interviews. Currently, training exists through the RACGP, which offers advice to GPs on specific military culture and delivering evidence-based treatments among the ex-serving ADF population.

Health Pathways (supported by most PHNs in Australia) is an online health information portal used by general practice, hospital specialists, nurses, allied health and other health professionals to support the ex-serving ADF population. Each Health Pathway is founded on nationally consistent evidence-based clinical guidelines and is localised within a local health district to support local assessment, management and referral. There are currently three ex-serving ADF member specific pathways, which have been localised by 28 of 31 PHNs. These are:

- Veteran Health Assessment: guides GPs to complete assessment adequately
- Veteran Support: options for referrals to specialised and allied health practitioners
- DVA: overview of health services and benefits provided by DVA.

In addition to the ex-serving specific pathways, there are numerous other pathways that provide specific information useful to ex-serving ADF members. These include mobility aids and equipment, physical activity and psychiatry telephone advice. Nationally, PHNs also have 1630 localised mental health specific pathways that can be accessed by ex-serving ADF members.

PHNs are currently auditing existing localised Health Pathways and developing a plan for a clinical pathway with related referral pages. Engagement with ex-serving ADF members and identifying champions to support these pathways will be critical.

The Defence NewAccess program is accessible to those in the ADF, providing a stepped care approach to those experiencing a mental health concern.[46] The program is based on Beyond Blue's New Access program, tailored for both ADF and Australian Public Service (APS) employees in the ADF and is used in addition to the existing employee assistance program that is available.[47] The program aims to ensure that members have access to varying levels of support, depending on the level of complexity associated with their mental health concern.[48] NewAccess as a program is also delivered by a range of PHNs at present across Australia for the general population as required and an evaluation conducted in 2015 found a recovery rate of

[46] Department of Defence Transparency Portal, Department of Defence Annual Report 2019-20, <https://www.transparency.gov.au/annual-reports/department-defence/reporting-year/2019-20-63>
[47] Ibid.
[48] Ibid.

67.5% in people that had participated in the program. This program also trains ex-serving ADF members to become coaches, which is highly effective and has received great feedback from users.[49]

A trial of the **InnoWell platform with Open Arms**[50] concluded in December 2020, with the primary aim of the trial being to co-design, develop, implement and evaluate the InnoWell Platform's ability to achieve improved outcomes for current and ex-serving ADF members and their families. The InnoWell Platform is a digital mental health platform that incorporates research, co-design and lived experiences into the platform. Participatory workshops conducted with individuals from the Open Arms community (including current and ex-serving ADP members and their families, health professionals, service managers, and administrators) showed that this model has the potential to:

- 'provide the opportunity for greater and better-informed personal choice in relation to options for care based on the level of need and personal preferences
- ensure transparency in care by providing the individual with access to all of their personal health information
- improve collaborative care and care continuity by allowing information to be shared securely with current and future providers.'[51]

Significant government investment has supported a network of eight **Veteran Wellbeing Centres**[52] located in areas with a high ex-serving ADF population These centres are intended to act as a shopfront for ex-serving ADF members and their families to access local support services that they need, including for transition, employment, health and social connection. The centres are at various stages of completion:

- open and providing services: Perth (ANZAC House Veteran Central), Adelaide (The Repat Veteran Wellbeing Centre), Townsville (The Oasis, stemming from Operation COMPASS)
- services being provided from temporary premises prior to Centre completion: Nowra, Wodonga and Darwin
- details being finalised (based on the recently announced expansion): South East Queensland and Tasmania.

Team Care Coordination (TCC) (Brisbane North PHN) is a service run by a clinical nurse to support referral to health professionals, services and programs in the local community. Team Care can be accessed by individuals with chronic health conditions who hold Veteran healthcare cards and are referred by general practitioners. A clinical triage of a referred case is conducted by a nurse, producing an assessment. Coordination support then continues over 12 weeks, in which the TCC nurse liaises with health care providers, NGOs, DVA and other stakeholders to ensure the client's needs are looked after. TCC also provides coordination support to widows of Veteran healthcare cards holders to ensure they can access the services they need.

Open Arms Veterans & Families Counselling provides a range of services and supports to current, transitioning and ex-serving ADF members and their families, including counselling, treatment programs and workshops.[53] To complement these services, Open Arms also provides

[49] Edwards, K., Lunn, J., Baass, B. (2015) beyondblue NewAccess Demonstration Independent Evaluation. Melbourne: Ernst & Young.
[50] Innowell (2021), Project Synergy, < https://www.innowell.org/project-synergy/>
[51] LaMonica HM, Davenport TA, Burns J, Cross S, Hodson S, Veitch J, Hickie IB. Technology-Enabled Mental Health Service Reform for Open Arms – Veterans and Families Counselling: Participatory Design Study JMIR Form Res 2019;3(3):e13662 doi: 10.2196/13662
[52] Department of Veteran Affairs (2021), Veteran Wellbeing Centres, <https://www.dva.gov.au/health-and-treatment/work-and-social-life-programs/work-and-social-support/veteran-wellbeing>
[53] Open Arms, Counselling, <https://www.openarms.gov.au/get-support/counselling>

a community and peer program. This involves community and peer advisors who draw on their own experiences and provide more intensive case management services and referrals to local support services for those with more complex care needs.[54]

Axis Clinic (Brisbane North PHN) is an example of a group program that exists outside of hospital settings for ex-serving ADF members to continue to manage mental health conditions and substance use. These programs assist with increasing functionality and rebuilding lives after transitioning from the military, and include scheduling activities, exercise and connecting with friend groups. Additional support offered includes peer support groups.

Mates4Mates[55] is a program based in Queensland that provides services for people whose lives have been impacted by service. This includes psychological services, physical rehabilitation, social connection activities and skills development training. Social connection activities provide the opportunity for ex-serving ADF members and families to experience mateship and support through linkage to a community of like-minded individuals, through activities such as coffee catch ups, creative arts, barbecues, hikes and school holiday programs.

4.2 Broader primary health care interventions for mental health

Right Care = Better Health Service (Eastern Melbourne PHN)[56] is a care initiative that supports people with complex and chronic health conditions through tailored, consumer centric and collaborative interdisciplinary care, ensuring that the right care is received at the right time. This program enables delivery of care coordination and self-management through information sharing and access to clinical and non-clinical community services.

The Way Back Support Service (TWB) (Australian Capital Territory PHN) is a program delivered by Wellways Australia in partnership with Beyond Blue and the PHNs in the Murrumbidgee region in NSW and the Murray, Great South Coast and Gippsland regions in Victoria.[57] This service is delivered to people who present to hospital following a suicide attempt, and includes collaboratively developing a safety and support plan, using tools and measures to establish links to community services, based on an individual's identified needs. TWB can link individuals with services as required and can support increasing engagement with existing services accessed (for example, Open Arms).

The Care Navigation pilot projects (HNECC PHN) in the HNECC region aimed to improve outcomes for vulnerable and disadvantaged individuals in three key areas:

1. Ability to navigate access to the right health, social and community services at the right time.
2. Ability to overcome barriers to accessing care.
3. Improved health literacy and self-management.

Trialled in four local government areas, Tamworth, Cessnock, Taree and Armidale, and provided by two separate organisations, the pilot project used care navigators to achieve the aims of the project. The program has been evaluated by external consultants. As a result of particularly strong results from the Care Navigation pilot working with the Ezidi refugee community and local health providers in Armidale, this pilot program has now been extended. This pilot has

[54] Open Arms, Community and peer program, <https://www.openarms.gov.au/get-support/community-and-peer-program>
[55] Mates4Mates, Social Connection Activities, <https://mates4mates.org/get-help/our-services/social-connection-activities>
[56] Eastern Melbourne PHN (2020), Right Care = Better Health working together to support people with complex needs in Melbourne's east and north-east <https://www.emphn.org.au/news-events/news/right-care-better-health-working-together-to-support-people-with-complex-needs-in-melbournes-east-and-north-east>
[57] Wellways, The Way Back Support Service, <https://www.wellways.org/our-services/the-way-back-support-service>

worked closely with a dedicated group of local general practices, the local hospital, pharmacies and social services to improve access for this community.

Headspace Centres[58] act as a one stop shop for mental health, physical health, alcohol and other drugs, work and study support for young people (12 to 25 years old), providing an integrated service delivery experience. There are over 100 centres across Australia which provide personalised connectivity into required support services based on individual needs. Integrated service delivery can drive efficiencies and reduce costs, allowing reach to be maximised.

Our Ways to Wellness[59] provides a social prescribing network that links patients or community members with sources of group support within the community via a 'Link Worker'. This aims to help the individual's mental and physical health through increased social contacts, access to services and improved social networks within the community. This program can help individuals with finding support groups, accessing practical services, getting involved in local activities, increasing physical activity and developing meaningful social connections.

Open Arms offers a centralised 24/7 phone number for crisis support. Other similar services include Lifeline, Suicide Call Back Service and Talk Suicide where accessibility is key to managing these high-risk scenarios.

Head to Health[60] is an Australian Government developed digital mental health gateway. Through the website, users can access telephone and online mental health services, including information pages and a chatbot that can provide tailored recommendations to support navigation. There are also pop-up clinics established in NSW, ACT and VIC.

[58] Headspace, Welcome to headspace centres, < https://headspace.org.au/welcome-to-headspace-centres/>
[59] Ways to Wellness, a whole community approach to ending social isolation through a social prescribing network, <https://waystowellness.org.au>
[60] Healthdirect, Head to Health, <https://www.healthdirect.gov.au/partners/head-to-health>