Science.
Compassion.
Action.

Suicide prevention for veterans

A toolkit for Primary Health Networks

June 2023

Black Dog Institute

THE oasis TOWNSVILLE

Acknowledgements

Black Dog Institute

The Black Dog Institute would like to acknowledge Aboriginal and Torres Strait Islander peoples as Australia's First People and Traditional Custodians. We value their cultures, identities, and continuing connection to country, waters, kin and community and pay our respects to Elders past and present. We are committed to making a positive contribution to the mental health and wellbeing of Aboriginal and Torres Strait Islander people across Australia. We would also like to acknowledge Australia's Aboriginal and Torres Strait Islander veterans and thank them for their service.

We acknowledge and remember all who we have lost to suicide and the impact this loss has had on families and communities. We recognise the contribution and the power of people with lived experience of suicide in informing, influencing and enhancing suicide prevention efforts. We also acknowledge all serving and ex-serving members of the Australian Defence Force and thank them for their service.

The Oasis Townsville

We acknowledge all veterans and their families connected with The Oasis Townsville. We acknowledge and pay respect to the past, present and emerging Traditional Custodians and Elders of this nation. We also acknowledge serving and ex-serving Aboriginal and Torres Strait Islander veterans as the very first warriors who stood as the guardians of this ancient country on which we live and work. We salute their commitment to an unbroken line of duty that began tens of thousands of years ago and continues to this very day.

Thank you

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Suicide prevention for veterans: Context and background

About the toolkit

Context

This toolkit was created by Black Dog Institute and The Oasis Townsville to support Primary Health Networks (PHNs) in the delivery of more targeted and responsive services to serving and ex-serving members of the Australian Defence Force (ADF). As findings continue to emerge from the Royal Commission into Defence and Veteran Suicide, governments are likely to come under increasing pressure to better fund programs and services that support veteran mental health.

As the commissioning bodies for primary health care services, Australia's 31 PHNs will likely be a key part of a national response to improve suicide outcomes for veterans. This toolkit was initially designed with Regional Suicide Prevention Coordinators in mind; however, it offers broad utility for anyone working in suicide prevention policy and practice as it relates to veteran mental health.

The toolkit is based on an adapted version of Black Dog Institute's Implementation Roadmap, which captures the Institute's experience in implementing systems approaches to suicide prevention in four steps: Exploration, Preparation, Implementation and Sustainment. Content is focused on the Exploration and Preparation phases; the remaining phases require the tailoring of suicide prevention interventions to meet local needs, which means they will need to be led by PHNs.

Drawing on the voices of lived and living experience

Engagement with veterans, their families and caregivers has been critical to the development of this toolkit. The project team hosted two consultations with veterans of varying ages from the Army, Navy and Airforce and their family members, and also invited written feedback from veterans and family members who couldn't attend these sessions. Participants were asked to share their stories and experiences of suicide, mental health challenges and help seeking, as well as their deep knowledge of what their community needs. While we sought to work as inclusively as possible, we acknowledge the lack of Aboriginal and Torres Strait Islander participants, among other intersectional voices, in these sessions.

In addition to these consultations, we also hosted a series of meetings with PHNs to better understand how this toolkit could help them commission effective services for veterans. These sessions revealed that PHNs have varying levels of engagement with the veterans in their regions – some are already leading remarkable health and mental health initiatives for this cohort, while others are yet to fund veteran-focused work. This toolkit is an introductory resource; as such, it will have particular utility for PHN teams who are in the early stages of building expertise and capacity in this domain.

Development

No one resource can tell the full story of the veteran experience. As such, this toolkit is intended to supplement other efforts to support veteran mental health in Australia, including those led nationally by Open Arms and the Department of Veterans' Affairs, as well as existing PHN-led programs that offer support to veterans in specific regions. We have chosen to focus on the key elements of suicide prevention in which Black Dog Institute and The Oasis Townsville can offer distinct value: namely, lived and living experience inclusion, suicide prevention program implementation and an understanding of the veteran experience.

The toolkit builds on the findings of a previous collaboration between these two organisations that produced *Prevention through connection: supporting veterans to thrive when their service ends*. This 2021 report documented the development and rollout of Operation Compass, a systems approach to suicide prevention led by the Northern Queensland PHN during the National Suicide Prevention Trial (NSPT) that has now been transitioned to The Oasis Townsville.

Black Dog Institute

Black Dog Institute is a national leader in mental health and suicide prevention research across the lifespan and the creator of Australia's first systems approach to suicide prevention. During the NSPT, the Institute supported the implementation of this systems approach, called Lifespan, at multiple trial sites across Australia, leading to the creation of the Implementation Road Map described on page 27. Black Dog Institute is also a champion of lived and living experience and has established both a Lived Experience Resource Network and the world-first Aboriginal and Torres Strait Islander Lived Experience Centre to amplify the voices of those with lived experience of suicide as core to suicide prevention research, practice and implementation.

The Oasis Townsville

The Oasis Townsville was established in 2019 with initial funding from the Queensland State Government and the Federal Department of Health as one of Australia's first Veterans' and Families' Hubs. In addition to continuing the delivery of several Operation Compass initiatives, The Oasis provides a 'single front door' for veterans, their families and friends in the Townsville area, helping them build and maintain social and professional connections that play an important role in supporting emotional wellbeing. Their vision is to have a thriving and well-supported veteran community in Townsville that enhances economic and social prosperity. Their goals include creating a welcoming environment, facilitating access to services that support human needs, providing a rewarding experience for all members and promoting a culture of veterans supporting veterans.

Note on terminology

For the purposes of this report, the term 'veteran' refers to anyone who has served in the ADF for any period and includes those still in active or reserve service. While ex-serving veterans are at higher risk of suicide than those still serving, this toolkit champions the need for more targeted and responsive suicide prevention for all veterans, no matter where they are in their service journey.

Executive summary

Australia's veterans face unacceptably high rates of suicide, but until recently, there have been few coordinated efforts to support them. With the Royal Commission into Defence and Veteran Suicide bringing the veteran experience into sharp relief, it's likely that the Australian health and mental health sector, including PHNs, will now be called upon to act.

This toolkit is an introductory guide designed to support PHNs to strengthen suicide prevention programs and services for veteran communities. Through our consultations and deep relationships with our PHN partners, we recognise that there is an absence of funding specifically earmarked for the veteran population, resulting in a lack of services designed for this cohort. While we are hopeful that this will change in light of findings from the Royal Commission, the toolkit also contains suggestions for low-cost adaptations of existing services to make them safe and appropriate for veteran users.

Toolkit content is presented in three sections:

Section 1

Provides a snapshot of the ever-changing datasets that paint a picture of veteran suicide in Australia.

Section 2

Focused on equipping PHNs with an understanding of the specific needs and experiences of the veteran community — an important first step in addressing veteran suicide. This section has been informed by the voices of veterans and their families, who generously shared their time and expertise with us in a series of consultation sessions. Their wisdom has been distilled into a series of simple, practical recommendations that can be applied in primary health settings and beyond.

Section 3

Looks at the how-to of embedding veteran needs and experiences at the heart of suicide prevention activities, as well as the practicalities of implementation. While PHNs are responsible for commissioning, it's important that they retain oversight of the design and delivery of these programs and play an active role in their ongoing evaluation. Content in this section has been structured as an adapted version of the Black Dog Institute Implementation Roadmap. A simple implementation science-led approach that translates the existing research evidence into the delivery of impactful suicide prevention programs.

This publication is intended to be a first step towards more mainstream recognition of Australia's veterans as a priority population in the suicide prevention space. As such, it is not intended to be a singular solution. We will continue to consult with the veteran community and to include an increasing diversity of voices in these conversations.

In particular, we would like to invite Aboriginal and Torres Strait Islander veterans to provide input and feedback. Despite concerted efforts and due to time constraints, First Nations participants were not in attendance at our consultation sessions and we acknowledge that their voices are missing from this resource. We encourage you to please email your feedback to suicideprevention@blackdog.org.au so that we can continue adapting this resource to offer value across multiple intersections of the veteran community.

Introduction

In June 2022, the Royal Commission into Defence and Veteran Suicide handed down their interim report. The findings were staggering: veterans, particularly ex-serving veterans, experience unacceptably high rates of suicide but are consistently let down by the systems that are meant to protect them.

According to the Australian Institute of Health and Welfare, 1,600 serving and ex-serving ADF members died by suicide between 1997 and 2020[1]. This number reflects only deaths that were certified as suicides; a wealth of issues relating to Australian suicide data[2] likely masks the true, higher number of suicide deaths within this cohort.

Suicide deaths among ADF members (1997–2020)

1600	1330	154	115
deaths	were ex-serving members	were permanent members	were reservists

Source: Australian Institute of Health and Welfare (2022). Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2020.

Suicide risk levels vary depending on sex and service status. Risks are particularly pronounced for ex-serving men who are involuntarily discharged for medical reasons and for ex-serving females[3].

'... suicide rates (after adjusting for age) between 1997 and 2020 were: 49% lower for male permanent ADF members; 46% lower for reserve ADF males; 27% higher for ex-serving ADF males; and 107% (or 2.07 times) higher for ex-serving ADF females.'[4]

Suicide rates by service status and sex (per 100,000 population per year)

Male			Female		
12.6	13.5	31.4	5.1	4.6	15.3
permanent	reserves	ex-serving	permanent	reserves	ex-serving

Source: Australian Institute of Health and Welfare (2022). Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2020.

1. Australian Institute of Health and Welfare (2022). Serving and ex-serving Australian Defence Force members who have served since 1985: suicide monitoring 1997 to 2020.
2. Walker, S (2008). The effects of certification and coding practices in Australia. Australian and New Zealand Journal of Public Health 32(2):126-30. DOI:10.1111/j.1753-6405.2008.00187.x
3. Australian Institute of Health and Welfare (updated December 2022). Australian Defence Force suicide monitoring.
4. ibid

This data reflects a growing understanding of the challenges that many ADF members face when leaving active service and making the transition into civilian life. This is the point at which they depart the supportive environment of the ADF, which includes built-in networks of mates and colleagues, a shared commitment to military service, and access to a plethora of health and other services designed to keep them fit and well.

By contrast, in the world beyond the ADF, many ex-serving members struggle with how to maintain their social networks, re-establish themselves in new careers and navigate the complex civilian health system.

Change is coming

The Interim Report from the Royal Commission identified a series of urgent changes required to protect veteran mental health and reduce suicide risk, including:

- enacting legislative reform to simplify compensation and rehabilitation systems designed to support veterans
- addressing challenges around processing claims for veterans, including clearing more than 40,000 backlogged claims and preventing their recurrence in the future
- improving legal protections for individuals who engage with the Royal Commission
- addressing the barriers that arise from parliamentary privilege that may constrain the Commission's ability to inquire into and receive evidence
- improving access to the Department of Defence (DoD) and DVA information for veterans and family members, including family members of deceased veterans.

These findings, though largely systemic, signal an expectation that governments will take action to overhaul veteran support services in Australia in the coming months and years. Improving veteran access to appropriate mental health care is one of the national priority areas set out by the Australian Government, while veterans themselves were identified in the Final Advice from the National Suicide Prevention Adviser, Ms Christine Morgan, as a priority population that is disproportionately affected by suicide.

At a more operational level, and alongside the efforts of DoD and DVA, both of which play a leading role in the delivery of veteran-specific support, compensation and health care services at the federal level, Australia's 31 PHNs are also likely to be called on to play a more central role in reaching this priority population with responsive, targeted and appropriate primary care. General practitioners (GPs) and other primary health care services are veterans' main avenue to health and mental health support; while we recognise that most PHNs don't currently receive funding for veteran-specific programs, veterans are part of every community and are equally entitled to have access to services that meet their needs.

5. Black Dog Institute (2021). Prevention through connection: supporting veterans to thrive when their service ends.

6. Australian Department of Health and Aged Care (updated 2023). How we support Primary Health Networks.

7. National Suicide Prevention Adviser (2020). Connected and Compassionate: Implementing a national whole of governments approach to suicide prevention (Final Advice).

The role of PHNs

Collectively, PHNs understand their role and responsibility in this space. In a joint submission to the Royal Commission, they noted:

'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 …'

The submission detailed a range of opportunities to deliver enhanced services to veterans over the short, medium and long term, including:

- supporting GPs and other service providers to work with veterans
- developing care pathways
- commissioning mental health services
- leading health promotion activities that improve health literacy and service engagement.

However, as outlined in the consultation with PHNs at the outset of this toolkit's development, many PHNs have little experience in commissioning and delivering mental health and suicide prevention services for veterans. In part, this is because veterans are rarely identified as a priority population in PHNs' annual needs assessments, which guide the allocation of PHN funding. Further, prior to the 2021 Census, little was known about the number of veterans in Australia or their geographic location, leaving PHNs with limited data of the veteran populations within their designated regions.

That is now changing: the addition of a new question in the 2021 Census that asked about respondents' ADF service has revealed crucial information about the number of veterans in Australia and where they're located. In light of this, and with the Royal Commission's final report expected in 2024, it is likely that PHNs will have an unprecedented opportunity to utilise veteran-specific data, recommendations and guidance and possibly designated funding to plan and provide effective support for veteran mental health.

8. Royal Commission into Defence and Veteran Suicide (2022). PHN Cooperative Submission.

What the Census tells us about Australia's veterans

- 581,139 Australians are currently serving or have previously served in the ADF:
  - 84,865 are currently serving
  - 496,276 have previously served
- 60% of ex-serving veterans have a long-term health condition
- 1 in 20 Australian households have at least one serving or ex-serving ADF resident

Sources: Australian Bureau of Statistics (2022). Service with the Australian Defence Force (Census). Australian Bureau of Statistics (2022). Australian Defence Force service.

Where are our veterans?

Top 15 regional areas for previous service members of the ADF, 2021

Statistical Area Level 3	Person count	Percentage (%)*
Townsville, QLD	8,661	1.7
Toowoomba, QLD	5,063	1.0
Rockingham, WA	4,717	1.0
Onkaparinga, SA	4,696	1.0
Mornington Peninsula, VIC	4,394	0.9
Ipswich Inner, QLD	4,217	0.9
Shoalhaven, NSW	4,123	0.8
Newcastle, NSW	4,083	0.8
Geelong, VIC	4,068	0.8
Gosford, NSW	3,877	0.8
Mandurah, WA	3,857	0.8
Wyong, NSW	3,735	0.8
Joondalup, WA	3,638	0.7
Stirling, WA	3,577	0.7
Tuggeranong, ACT	3,499	0.7

Source: Australian Bureau of Statistics (2022). Australian Defence Force service.

* Percentage of total number of previous service members currently in Australia

Section 2

About the veteran experience

Like all priority populations, veterans have unique characteristics, experiences and needs that shape both their suicide risk and their capacity to engage with suicide prevention services. The unique nature of military service refers to the impacts of ADF service on veterans' health and wellbeing. These impacts can be positive, such as the 'healthy soldier effect', in which veterans benefit from a range of protective factors during their time in active service,[9] and negative, such as exposure to significant stressors that are unlikely to impact the general population.

'ADF members can be subject to workplace stressors from exposure to combat, periodical geographical relocations, and lengthy separation from family. Military service also increases the likelihood of exposure to life threatening situations, which may result in physical and mental trauma and moral injury.'[10]

Understanding these characteristics is crucial to delivering responsive and effective interventions that meet veterans where they are. As described earlier, this toolkit has been shaped by a series of consultations with the veteran community (see page 6). The recurring themes that emerged from these sessions have been captured below, along with recommendations to help PHNs operationalise these findings in future commissioning and service provision activities in primary health setting.

While DoD and DVA and related veteran organisations like ex-service organisations (ESOs) offer a wide range of supportive services for current and ex-serving ADF members, veterans like anyone else in the community are entitled to choose how and where they seek support. As such, PHNs and mainstream primary health care providers cannot assume that veterans can or should seek help elsewhere and should be ready and able to provide a variety of care options for the veteran community.

9. Australian Institute of Health and Welfare (updated July 2022). Who is a veteran?

10. ibid

Disclosing veteran status in healthcare environments

Many veterans are proud of their ADF service, but consultation participants described facing mixed reactions when disclosing their veteran status in mainstream health care environments. These included:

- being "palmed off" by GPs and other health care providers because of a misplaced belief DoD and DVA are solely responsible for looking after veterans' physical and mental health
- receiving inadequate or inappropriate referrals from GPs who weren't well versed in local and national support services that are relevant to veteran health
- being refused care or being expected to pay the entire cost of a consultation out of pocket because a provider didn't accept their DVA Veteran Card[11] or was unfamiliar with the DVA claims process
- facing discrimination from health care providers who viewed them as "dangerous" due to their PTSD or other trauma-related conditions
- feeling triggered or unsafe in noisy, crowded waiting rooms.

11.A DVA Veteran Card signifies that DVA will cover some or all of the cost of health treatment for certain conditions. Providers invoice DVA for reimbursement in line with DVA fee schedules for veterans who hold one of these cards and can also prescribe items through the Repatriation Pharmaceutical Benefits Scheme. Source: Department of Veterans' Affairs (2023). Veteran Card.

Considerations for PHNs

General practice environments are often the first point of contact for veterans seeking support for their mental health. Supporting GPs and practice teams to create more welcoming, responsive and trauma-informed spaces and services for veterans would likely have a significant impact on client wellbeing.

This could include:

- providing veteran-specific training for GPs and practice staff that covers the unique physical and mental health needs of this cohort
- administrative training to support practices to navigate the complexities of DVA benefit schemes and claims processes, enabling the provision of seamless and inclusive service at no increased cost to the client
- engaging with programs like Veteran Health Pathways, which can support GPs to make targeted referrals to services that are safe for, and trusted by, the veteran community
- providing an opportunity to identify as current or former ADF personnel on patient intake forms to help practice staff and GPs to work appropriately with veteran clients.

Case study: Enhancing Primary Care of Veterans GP training

Enhancing Primary Care for Veterans was a GP training package commissioned by the Northern Queensland PHN as part of the National Suicide Prevention Trial. Created by a veteran and GP, the training was informed by veterans and their families during a series of consultation sessions led by the Operation Compass team.

Northern Australian Primary Health Limited (NAPHL) was commissioned to deliver the training to GPs, practice nurses and practice managers. Course content was intended to improve participants' knowledge of veteran culture, health pathways and health issues, as well as the barriers that veterans faced in accessing care, including:

- common health and mental health complaints impacting the veteran community
- ADF service life, the challenges of transitioning from active service, and the channels that serving and ex-serving ADF personnel may use to access health and mental health
- veterans' entitlements under Medicare and DVA, such as information about Veteran Cards, Veteran Health Assessments, medication reviews, incapacity payments and rehabilitation services, among others
- DVA administrative claims processes, including claims timelines, fee schedules and specific MBS and DVA billing numbers.

The training was delivered nationally via two online workshops and three face-to-face education sessions that took place in the Northern Queensland PHN region. Participants received Continuing Professional Development points for attending.

In total, more than 200 people attended. Post-event surveys showed that a significant majority of attendees agreed that the content met their learning needs and was relevant to their professional practice. These events were accompanied by a suite of marketing materials that encouraged ex-serving veterans to identify their veteran status when attending GP appointments.

The Oasis Townsville is currently updating the training and seeking support for a national rollout.

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Transition | Connection | Integration

Diversity within the veteran community

While the term 'veteran' may bring to mind a white, older male, Australia's veterans include Aboriginal and Torres Strait Islander peoples, people from diverse cultural and linguistic backgrounds, people with diverse gender and sexual identities, and people from different age groups and family situations, among others. Serving the veteran community means acknowledging this diversity and intersectionality and developing interventions that are responsive to different types of need.

Lance Corporal Shannon is an Aboriginal woman of Yaegl Country
Facebook - ©Australian Army

Considerations for PHNs

In some cases, interventions that target the unique needs of a particular veteran cohort, such as Aboriginal and Torres Strait Islander people or women, may be appropriate depending on local demographics and risk factors. As will be described later in this section, including lived experience voices that capture a diversity of veteran identities is crucial and may involve reaching into specific networks, such as First Nations, LGBTIQ+ or women's groups. This may require research into local veteran support groups to better understand what's already available and what could be enhanced or adapted to fit.

Further, PHN staff should challenge commonly held notions of who veterans are and consider whether certain services, programs or initiatives will suit people at various intersections. For example, the toolkit consultations highlighted that not all veterans feel comfortable engaging with RSLs. As such, PHNs should consider commissioning and partnering with a range of organisations, including local groups, to ensure all veterans feel comfortable.

Case study: Women Veterans Network Australia

The Women Veterans Network Australia is a national network for female veterans that was co-founded by Australian Army veterans Ramon Fenton and Barbara Craven-Griffiths in 2013. Today, the Network has 25 regional groups across Australia.

WVNA provides female veterans with face-to-face and online connection, which is an important support for women who have left active service. One-size-fits-all approaches to veteran mental health tend to focus on the predominant veteran experience (white, older, male), but female veterans, who make up 20.6 per cent of current ADF personnel and 13.4 per cent of ex-serving veterans, face substantially different challenges to their male counterparts. These include reproductive and female-specific health issues and elevated risks of sexual assault and domestic violence, all of which pose various risks to women's emotional wellbeing.

WVNA leverages the shared experience of service life to connect ex-serving female veterans to one another at both local and national levels. Members participate in coffee catch ups and other in-person events and engage extensively in the online WVNA community. The Network now boasts 11,000 followers on its public-facing Facebook page and 3,000 on its closed forum pages. Informal referrals, in which members connect one another with local 'veteran-safe' services and resources, are common within the group.

PHNs and commissioned service organisations seeking lived experience expertise to support the development and delivery of veteran health and mental health services can contact WVNA.

www.wvna.org.au

The importance of peer connections

The unique nature of the veteran experience often binds veterans to one another through a sense of shared connection. During the consultations that shaped this toolkit, many participants talked about the significant potential of peer work as a protective and connective factor for veterans in need of mental health support.

Leveraging these veteran connections and the trust and mateship that result from them can be key to finding an entry point into veteran communities and can also help guide veterans to seek help — one study from the US showed that veterans are more likely to seek evidence-based psychological therapy if it's recommended by other veterans, and that peer support programs might offer numerous social, therapeutic and other benefits for veterans with PTSD.[12]

Considerations for PHNs

Suicide prevention programs and services that include veteran peer workers are likely to address a significantly unmet need. These could include, but are not limited to, linking in with existing peer programs led by organisations like Open Arms, which is a national DVA-led veterans' and families' counselling service), The Oasis Townsville and others, and establishing new peer worker roles that could provide upstream connections and support during pivotal moments such as during a crisis response or during intake to, or discharge from, hospital emergency departments.

12. Military Medicine (2015), Volume 180, Issue 8, Pages 851–856. Veterans' Perspectives on Benefits and Drawbacks of Peer Support for Posttraumatic Stress Disorder. https://doi.org/10.7205/MILMED-D-14-00536 https://academic.oup.com/milmed/article/180/8/851/4160556

Case study: The Open Arms Community and Peer Program

The Open Arms – Veterans and Families Counselling Community and Peer Program is a national peer support service for ex-serving Australian Defence Force (ADF) veterans. The program is offered as a complement to Open Arms counselling, group program services and other Department of Veterans' Affairs (DVA) supports.

Open Arms Peers are veterans or family members with lived experience of military service and mental health recovery and healing. They provide support to veterans and families on a wide range of post-service issues, including:

- connecting with tribe and community, activities and interests, networks and services
- navigating transition and post-service identity for both veterans and families
- personal relationships and family dynamics, including managing change
- engaging with what's important, including re-engaging with what gives purpose and meaning
- identifying education and employment goals and navigating finances
- improving physical health
- making sense of mental health and wellbeing and creating a pathway to recovery
- understanding and managing stress and distress, including thoughts of suicide

Peers receive training that prepares them to work closely and effectively with their veteran and family consumers and referring them to relevant local services for further support. There are more than 70 peers, and Open Arms has a footprint of more than 35 offices across Australia.

Where possible, veterans and family consumers are matched to a peer with similar lived experiences. Anyone who has served at least one day in the ADF, their families and some reservists are likely to meet eligibility requirements.

PHNs and service providers should be aware of the Community and Peer Program as the largest veteran and family full-time, employed peer worker network in Australia. Additionally, Open Arms is a leading mental health support service designed to meet veteran needs.

openarms.gov.au/get-support/community-and-peer-program

OPEN Veterans & Families Counselling ARMS

Navigating the health system

After years of receiving care through DoD and DVA, many veterans are unfamiliar with the mainstream health system and often struggle to navigate it, leaving some receiving care too late and others not receiving care at all. Equipping veterans with the knowledge and support they need to seek help can encourage them to access upstream prevention supports and to choose how, when and where they access the care they need long before the point of crisis.

Considerations for PHNs

Building strong connections with local health districts and ESOs can support PHNs to develop care and referral pathways and navigation support for veterans and their families. Service mapping across geographical areas can assist PHNs to identify existing resources and services and identify gaps that can be solved by strategic positioning. As part of effective suicide prevention planning and commissioning, adding veteran representatives to locally formed suicide prevention collaboratives will ensure the veteran perspective is considered within local suicide prevention activities.

Case study: Veterans Connect Care Navigation Service

Veterans Connect is a care navigation program funded by the Hunter New England and Central Coast (HNECC) PHN and delivered by regional community services provider Social Futures. The program helps veterans, their families and carers to identify and access timely and appropriate health and mental health support when and where they need it.

The HNECC PHN region is home to a significant number of ex-ADF personnel and their families; as such, Veterans Connect is currently being trialled in the Central Coast LGA.

The service is led by professional care navigators who can help clients source health information; develop their health knowledge, resilience and ability to self-manage and seek help; connect them to health, specialist, social and community services; discuss safety planning; and provide support with practical challenges such as transport to and from appointments.

It has a strong focus on building relationships and care and referral pathways with local GPs and health centres, allied health services, veteran support services, community services and peer support groups. Veterans can refer themselves or be referred by their families, GPs, allied health professionals, community service organisations or peer support groups.

The Veterans Connect trial will run until June 2024.

thephn.com.au/programs-resources/care-navigation

The care they want, when they want it

Consultation participants described struggling to access mental health care services when and where they needed it, particularly if they lived in a regional location. Specialist referrals resulted in wait times that were too long, leaving many veterans with nowhere to turn during periods of distress.

Numerous participants expressed a preference for face-to-face care but described challenges in accessing their preferred GP or mental health provider when they needed to make an appointment. In turn, this forced them to choose between not receiving support or being forced to see another provider who they didn't know and with whom they had not established a rapport, necessitating a further recounting of the traumatic experiences that had originally led them to seek help.

After-hours care was repeatedly highlighted as a critical service gap. Many veteran-specific services are unavailable overnight or redirect to third-party providers who provide what consultation experience participants described as inadequate support. Mainstream help services like Lifeline are staffed by people who are unfamiliar with the veteran experience and hospital emergency departments are not considered safe spaces for someone in crisis.

Considerations for PHNs

Collaboration is key: PHNs cannot solve the challenge of service gaps on their own. Building relationships with local health districts, first responders and local hospital emergency departments can create new opportunities to deliver crisis support beyond established care provision pathways, as can the inclusion of peer workers and mental health nurses in alternative crisis response programs.

Investing in service needs/gap analyses and regular consultation sessions in partnership with local veterans can pave the way for PHNs to better understand the veteran experience. This can result in the commissioning and delivery of veteran-responsive services, the adaptation or promotion of existing services that are experiencing limited uptake, and the identification of existing peer-led initiatives (such as Veterans' and Families' Hubs, veteran Facebook groups, informal veteran networks and grassroots peer support programs) that operate beyond standard business hours.

Elsewhere, providing veteran-specific training for local primary health providers can help build workforce capacity by shortening wait times and creating expanded access to safe and accessible care for veterans seeking support.

Rewarding good health

Many suicide prevention services are necessarily focused on crisis response, while general mental health services tend to prioritise poor mental health outcomes as a prerequisite for accessing support. During the toolkit consultations, veterans identified the importance of good physical health as an enhancing factor for mental health and highlighted the need for more holistic, upstream services that emphasise the importance of exercise, nutrition, social connection and routine.

exercise

social interaction

routine

Considerations for PHNs

Low-cost adaptations of existing physical health and social programs (such as diabetes clinics, chronic pain services and men's' groups) could be adapted to offer veteran-specific drop-ins. PHNs can also connect with and promote upstream services, such as the Australian National Veterans Arts Museum and Veteran Sport Australia, that emphasise wellness and social connection.

PHNs should also consider leveraging veterans' innate instinct to help others, which has been honed over their period of ADF service. Grassroots initiatives that encourage social connection can deliver meaningful benefit at minimal cost. Be aware of a range of different upstream supports, including arts and sports programs, to promote and refer veterans and their families to, for example, The Australian National Veterans Arts Museum and Veteran Sport Australia.

Case study: Operation Compass Community Grants Program

One of the flagship programs to emerge from Operation Compass, the Community Grants Program was a grassroots initiative that delivered upstream mental health and suicide prevention initiatives for veterans in the Townsville area.

The program provided up to $25,000 in funding for innovative projects led by veteran and community organisations, including smaller entities that might otherwise have struggled to access grant funding opportunities. Over three rounds, the Community Grants program funded 27 projects in five strategic areas:

- Suicide prevention
- Wellbeing and social connection
- Improving mental health
- Improving physical health
- Promoting wellbeing and wellness

In large part, funded projects emphasised health, wellbeing and social connection rather than directly addressing mental health and suicide risk. The aim was to help veterans build resilience and social networks that would provide structure and a sense of mateship in their lives outside the ADF.

Projects included:

- Ashvin's Health Cycle, a static bicycle training program that emphasised social inclusion and physical and mental health through the provision of 'social prescriptions' from local pharmacy partners.
- The Cameleers, a group of veterans who partnered with local Indigenous communities to run field trips and archaeological digs.
- Shed 3, a local not-for-profit organisation that ran weekly art workshops.
- BrothersNBooks, a reading initiative that encouraged veterans to read books, share their stories and reduce stigma around mental ill health.

Other projects leveraged veterans' innate instinct to help others: Operation FARMER ASSIST invited veterans to provide physical support, such as general labour, repairs and fencing, to local farmers.

Not all the projects received the maximum funding allocation; in fact, a number of the most successful projects were funded for less than $10,000. Participants were highly engaged with the program, which reached more than 500 people. Several community grant-funded projects have since been transitioned into the Townsville community.

theoasistownsville.org.au/lessons-from-compass

Section 3

Tools and practical actions

This final section of this document is focused on transforming the toolkit consultation learnings into practical actions towards PHN-led suicide prevention for veteran communities.

The Black Dog Institute Implementation Roadmap

The following content is based on the Exploration and Preparation steps of the adapted Black Dog Institute Implementation Roadmap. This is a simple implementation science-led approach that translates the existing research evidence into the delivery of impactful suicide prevention programs that form part of a systems approach. Purposeful, active, and integrated approaches to implementation have been shown to yield better implementation outcomes, improve services and lead to improved outcomes for patients and clients. As such, we have adapted the existing roadmap to guide PHNs in the planned and intentional rollout of veteran-specific suicide prevention programs.

Implementation Road Map

Phase 01 - Exploration (0-12 months)

Page 28

Theme

Establish a strong collaborative network, build a detailed understanding of the community needs and work together to develop a collective plan for action.

Key Tasks

1. Build a veteran network
2. Include lived and living experience
3. Access and understand the latest expertise
4. Identify needs and gaps
5. Identify solutions that fit

Phase 02 - Preparation (12-18 months)

Page 35

Theme

Get ready to implement your action plan by establishing the structures, processes, tools and training required to make it a success.

Key Tasks

1. Develop your action plan
2. Plan evaluation activities

Phase 03 - Implementation (18-36 months)

Theme

Commence implementation supported by strong learning, measurement and evaluation. This phase is typically one of the more challenging as people encounter the discomfort of change and challenge of setbacks. Be bold and own successes and failures in the spirit of continued learning.

Key Tasks

1. Commence implementation of activities in action plan
2. Embed reflection cycles into implementation actions to ensure strategic learning
3. Develop a communication plan

Phase 04 - Sustainment (Ongoing)

Theme

Consolidate and embed interventions to ensure their sustainability. Evaluate the outcomes and impact of specific initiatives using qualitative and quantitative data, including community stories and lived experience voices.

Key Tasks

1. Evaluate outcomes and impact of initiatives
2. Communicate findings and learnings
3. Continue cycles of action and reflection

1. Exploration

Build a veteran network

Suicide prevention for veterans will be ineffective without extensive engagement with veterans and families. If done well, this engagement can help PHNs build trusting relationships that will establish their credibility within the veteran community. PHNs seeking to build veteran connections could consider reaching out to:

- local suicide prevention networks that have veteran members
- established veteran groups like Pro Patria and WVNA
- nearest Veterans' and Families' Hub
- ex-service organisations
- the Open Arms Community and Peer Program
- mental health and suicide prevention organisations, like Black Dog Institute and Roses in the Ocean, with established suicide prevention programs, communities of practice and lived and living experience networks that target or include veterans.

It's important to make these approaches with readiness in mind. Read more on page 30.

Veterans' and Families' Hubs

Veterans' and Families' Hubs are funded by DVA to deliver support and services to veterans and their families. In 2019, DVA committed $30 million to establish the first six Veterans' and Families' Hubs in the following regions:

Existing Hubs
Veteran Central, Perth, WA
Veteran Wellbeing Centre, Adelaide, SA
The Oasis Townsville, Townsville, QLD
Nowra Veteran Wellbeing Centre, Nowra, NSW
Hume Veterans Information Centre, Wodonga, VIC
Mates4Mates, Darwin, NT

In October 2022, DVA announced another $46.7 million in funding support for an additional ten hubs:

New Hubs: Proposed Locations
Hawkesbury region, NSW
Hunter region, NSW
Tweed/North Coast region, NSW
Queanbeyan, NSW
Ipswich, QLD
Northern Adelaide, SA
Southwest Perth, WA
Surf Coast/Geelong region, VIC
Burnie, TAS
Caboolture, Southeast QLD

Source: Department of Veterans' Affairs (2023). Veterans' and Families' Hubs.

Include lived and living experience

The valuable voices of lived and living experience are increasingly becoming a non-negotiable component of mental health and suicide prevention research, policy and practice. For the veteran community, which is built on trust and shared experiences that are unique to ADF personnel, lived experience input is essential to the development of suicide prevention interventions that meet the needs of this cohort. PHNs can use their veteran networks (described on page 28) to start recruiting lived experience participants.

The information below provides an introduction to veteran lived experience, as well as how to engage effectively and safely with veterans to maximise their contributions.

Defining lived and living experience

Lived and living experience refers to people who have personal experiences with mental health challenges or suicidal thoughts or actions, either now or in the past. This includes the person living with the mental illness or suicidality and those who care for them, as well as people who have been impacted or bereaved by suicide.

In the veteran context, lived experience refers not only to experiences of mental health challenges and suicide but also to the stories and events that have contributed to their mental health challenges as a direct result of their ADF service.

For example, veterans experience higher rates of PTSD than the general population[13], in part due to their more frequent exposure to traumatic events in the line of duty. As such, mental health and suicide prevention interventions for this cohort must be based on lived experience of the circumstances that underpin veteran mental health challenges and suicidality, as well as on the experience of mental health challenges and suicidality itself.

Engaging with lived and living experience

Black Dog Institute has developed a participation framework that can help guide PHNs seeking to integrate veteran lived experience into their suicide prevention programming. Described briefly, the participation framework emphasises the need to move suicide prevention design and delivery away from a 'doing at' approach, in which clinicians and professionals lead the work on behalf of priority populations like veterans, and towards a 'doing with & led by' process where those priority populations are equal and reciprocal partners in the design of interventions intended to serve them.

13. Australian Government Department of Veterans' Affairs (updated 2021), Managing posttraumatic stress disorder (PTSD).

Developing principles for lived experience engagement can also help project stakeholders articulate and understand the lived experience role. These principles should act as a statement of intent to ensure that lived experience contributions are authentic, safe and effective. They should be unique to each individual project and developed in partnership between veterans and project staff.

Consider intersectionality

Suicide prevention must address the entirety of people's lives and experiences. For veterans, this means ensuring that interventions address the mental health implications of their ADF service while still recognising them as whole and complex people beyond the 'veteran' label.

As a result, when seeking lived experience input into the design and delivery of suicide prevention programs and services, PHNs should take care to seek diverse and intersectional perspectives (see more on page 16).

Example principles of lived experience engagement

- Empowerment
- Effective engagement
- Respect and value
- Diversity and inclusion

Source: Black Dog Institute (2023). Lived Experience Engagement Framework.

Include families

Where possible, and with the consent of veteran participants, families and carers should be included in conversations and co-design processes as they relate to veteran suicide. Their experiences of living with and caring for veterans can provide valuable insights into the veteran experience from a different perspective. Families and caregivers have been described as *'the last deployment'*[14] for many veterans leaving active service, the importance of these connections continues to grow: *'When this is all over, that is your first peer group.'*[15] It's worth noting that the term 'family' doesn't always constitute biological bonds — veterans often forge close, familial connections with 'chosen families' who also offer value in this space.

Consider readiness

Veterans and their families with lived experience of mental health challenges and/or suicide are often very willing to provide insights, knowledge and expertise to develop or adapt initiatives that they believe will help their peers. Some may feel a responsibility to take part in many lived experience opportunities; however, talking about experiences of mental illness, suicidality and bereavement can be triggering and can lead to burnout and emotional distress.

When inviting veterans to contribute to suicide prevention activities, assessing their readiness and asking them to complete a readiness checklist is an important step in ensuring their safety. Making use of multiple veteran representatives can also reduce the pressure on those who feel compelled to contribute when asked.

14. Black Dog Institute (2021). Prevention through connection: supporting veterans to thrive when their service ends.
15. ibid

Key readiness questions for veterans

- What is motivating me to be involved in this work?
- If I cannot drive the change I want to see in the suicide prevention space, am I still happy to be involved?
- Have I thought about words, topics or scenarios that might be activating/upsetting to me?
- How do I feel when someone expresses opinions or experiences that I don't agree with?

Source: Black Dog Institute (2023). Your Readiness. [Internal document].

Pay for expertise

When inviting people with lived experience to contribute to the development of programs and services, PHNs should compensate them for their time and expertise. Paid participation, where appropriate, reflects the vital nature of lived experience as an important form of qualitative evidence that enables effective suicide prevention policies and programs.

Access and understand the latest expertise

The evidence base for veteran suicide prevention is growing. While it remains incomplete, today there are a range of important sources of information that PHNs should consult prior to developing interventions or commissioning services for this cohort.

- Australian Bureau of Statistics
- Royal Commission into Defence and Veteran Suicide
- Australian Institute of Health and Welfare
- Department of Veterans Affairs
- Black Dog Institute and Operation Compass

As a starting point, PHNs should review the available data on veteran suicides and familiarise themselves with the factors that increase veteran suicide risk. Some of these risk factors have been described earlier in this document; however, the following sources provide a more complete picture.

The Final Report from the Royal Commission into Defence and Veteran Suicide is due for release in June 2024. This document is expected to contain important insights into systemic and other reforms that could play a meaningful role in reducing veteran suicide rates.

The updated principles of suicide prevention for the veteran community

1. **Acknowledge the burden of veteran suicide**
We must recognise and acknowledge the national impact of suicide within the veteran community. Veterans are and should be recognised as a priority population in Australia's suicide prevention efforts.

2. **Empower veterans**
We must support veterans to stand at the forefront of suicide prevention for their communities by funding meaningful programs that acknowledge their trauma, draw on their strengths and draw on their deep knowledge of what will help.

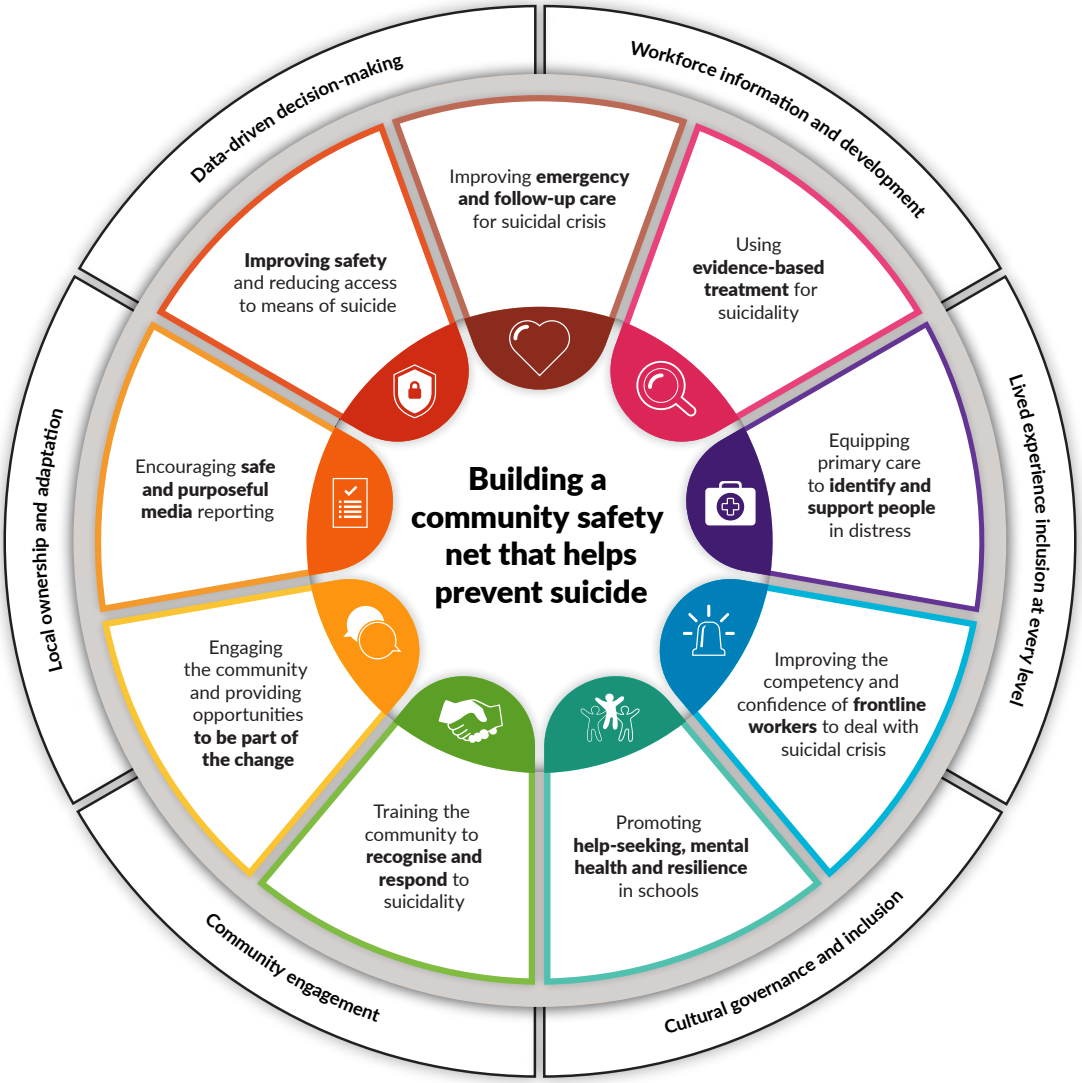
3. **Take a holistic approach**
Preventing suicide requires much more than a focus on intervention at the point of crisis. A holistic suicide prevention strategy that emphasises the importance of upstream wellbeing support and connection, as well as crisis response and postvention, and that can be localised within individual communities, is crucial.

4. **Lead with lived experience**
Veterans and their families are the experts in preventing suicide within this priority population. Their lived experience input, knowledge and wisdom must sit at the forefront of all suicide prevention efforts.

5. **Champion collaboration**
Veteran suicide is everyone's business. Veterans and their families, the community, and local, state and national agencies must all work together to develop the expertise and skills to contribute to suicide prevention.

6. **Support those at risk**
If tragedy strikes, we need to better support the families and mates of those affected. We must train communities to assist during postvention and empower and equip veterans and families to help each other. We are the first line of defence.

Source: Adapted from Black Dog Institute (2021). Prevention through connection: supporting veterans to thrive when their service ends.



Identify needs and gaps

Prior to commissioning or delivering any interventions, PHNs should establish a detailed snapshot of local suicide prevention activities that serve the veteran community. In addition to completing an annual needs assessment, PHNs should consider implementing a systems approach to suicide prevention, such as Black Dog Institute's Lifespan wheel, and mapping their existing services and programs against it. Growing evidence indicates that multi-component systems approaches, implemented simultaneously, are likely to be the most effective way of reducing suicide[16].

Lifespan

Lifespan combines nine evidence-based suicide prevention strategies into a single community-led approach. PHNs can use the Lifespan wheel, shown above, to identify any veteran-relevant services and programs that already exist in their communities and to articulate gaps that need to be addressed. It should be noted that Lifespan is a guide only and all nine strategies may not be relevant to every PHN region, or to the veteran community. PHNs should feel free to adapt the Lifespan model to meet the specific requirements of veterans in their local community.

16. Source: Black Dog Institute (2020). Getting Started: Implementing a Systems Approach to Suicide Prevention.

Source: Operation Compass

Adapting the Lifespan wheel

During the National Suicide Prevention Trial (NSPT), and with support from Black Dog Institute, the Operation Compass team at Northern Queensland PHN transformed the Lifespan wheel into an eight-point compass that captured the key areas of focus for their NSPT activity.

'This approach was … designed to present the LifeSpan systems approach in a format that spoke to the veteran community and that was aligned with the Operation Compass brand. Team members agreed that they needed a strategic and methodical approach to guide their suicide prevention work and that LifeSpan was a useful starting point.'[17]

Identify solutions that fit

Localise solutions

After building a veteran network, engaging with lived and living experience, and assessing veteran-relevant services and service gaps in their local areas, PHNs can start developing or commissioning solutions based on their findings. There is no one-size-fits-all approach to suicide prevention, including suicide prevention for veterans; as such, PHNs should seek to establish highly localised interventions that are developed in partnership with their local veteran community and to adapt existing health and mainstream mental health services to be safe for, and responsive to, this cohort.

Veteran-led community level organisations often step in to fill gaps in government-funded health, mental health and suicide prevention services for veterans; PHNs should consider supporting these local, veteran-led services both as a way of meeting service shortages and leveraging initiatives that have already established trust within the veteran community.

Consider the spectrum of suicide prevention needs

The veteran community is broad and intersectional, as described earlier. As such, suicide prevention programs must integrate the lived and living experience perspectives of veterans and their families from all walks of life. Programs should also seek to meet veteran needs at different points in time, not only at the point of crisis — upstream services can help prevent people reaching the point of suicidal ideation or a suicide attempt by keeping them socially, professionally and physically engaged, while veteran-specific after-hours services can provide an additional level of safety for people who need support beyond business hours.

17. Black Dog Institute (2021). Prevention through connection: supporting veterans to thrive when their service ends.

2. Preparation

Develop your action plan

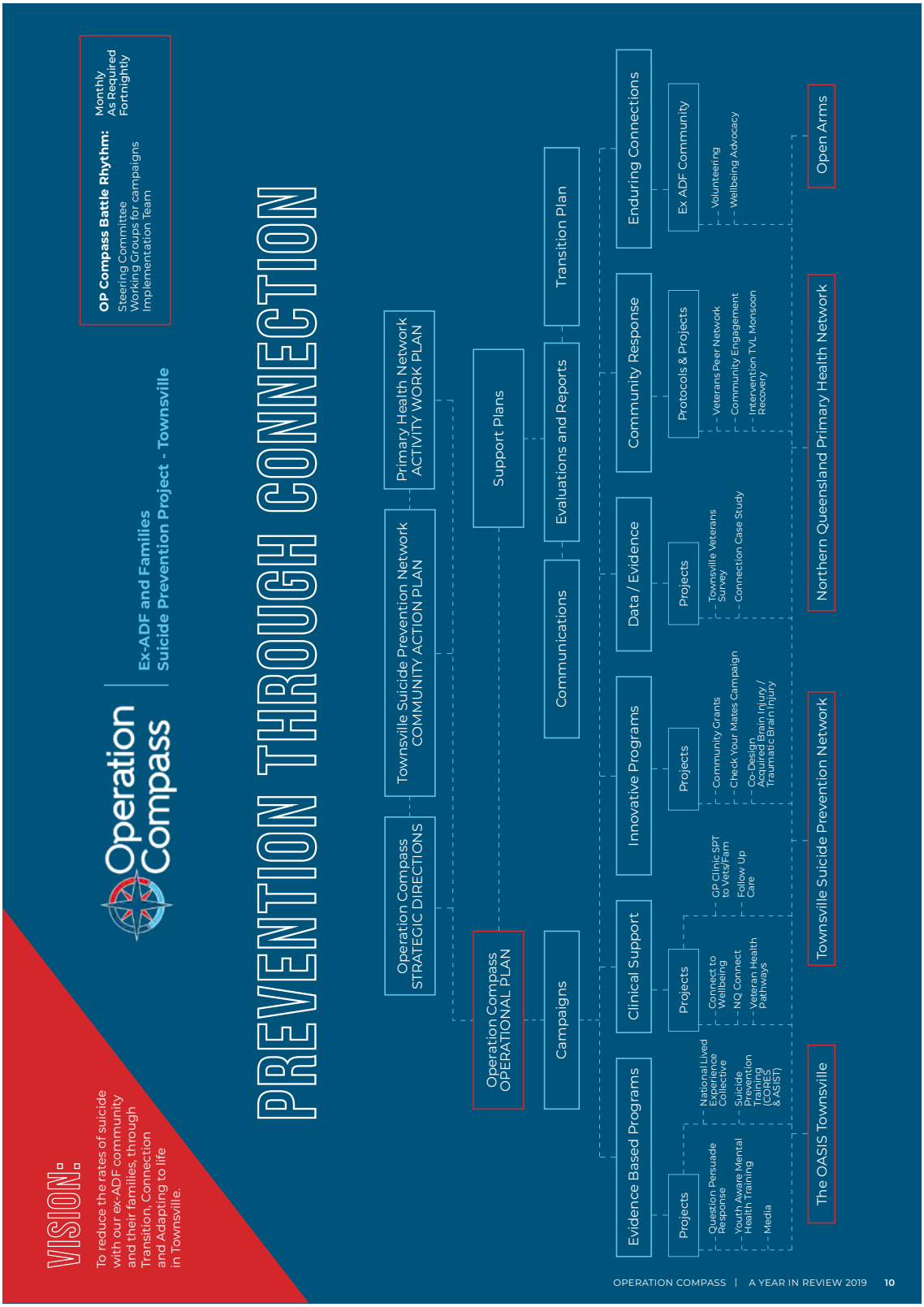
An action plan is a central document that provides a shared vision for all your project stakeholders by outlining project rationale, objectives and stakeholders. Action plans don't need to be complex. At a minimum, consider including the following:

STEPS	ACTIVITIES	SUGGESTED ACTIONS
Theory of change	Develop a visual or written description of how your intervention will lead to a desired change. Consider what you're trying to do and why.	Refer to example theory of change below.
Actions	Identify the steps you need to take to realise your theory of change.	Consider any other planned enhancements to local mental health and suicide prevention services and their potential to contribute to your theory of change.
Participants	Consider who will be involved in the work and how you will engage them.	Identify services, agencies or representatives who need to be involved in this work. Refer to 'Build a veteran network' on page 28. Identify which stakeholder/s will be responsible for each action described above. Consider feedback mechanisms — what channels and prompts will you put in place to enable the provision of regular feedback?
Resources	Review the resources you have and identify what else you need to operationalise your project.	Black Dog Institute's Suicide Prevention Network houses a range of implementation resources.
Timeline	Map out how long the work will take and identify key project milestones.	
Outcomes	Articulate who will benefit from this work and how.	
Evaluation	Think about what success looks like. How will you know if you've achieved your goal?	Refer to 'Build in evaluation' on page 28.

Because your focus will be developing suicide prevention interventions or adapting mainstream services for veterans, your action plan should clearly articulate how the project will be informed by, and responsive to, veteran needs and experiences. In particular, your theory of change should specify desired outcomes for veterans, and your participant list should include lived and living experience expertise, as well as engagement with veteran or veteran-aligned organisations.

Example theory of change

During Operation Compass, the Northern Queensland PHN team developed a single-page theory of change they called the Plan on a Page. This plan described the change that the project was intended to achieve and the activities that would enable it to be realised.



Plan evaluation activities

Evaluation should be built in from the beginning of a program and become part of a cycle of continuous improvement over the life of the work. Evaluation processes don't need to be complex or overwhelming and can be simplified to reflect the needs, budgets and expertise of the teams responsible for delivering them. At their most basic, evaluation activities should seek to answer the following three key questions:

- What works?
- Why does it work?
- How effectively does it work?

Six steps towards effective evaluation

The following steps describe the evaluation process. These steps can be applied to an entire program, an individual project or intervention, or specific components of a piece of work, such as project principles or ways of working.

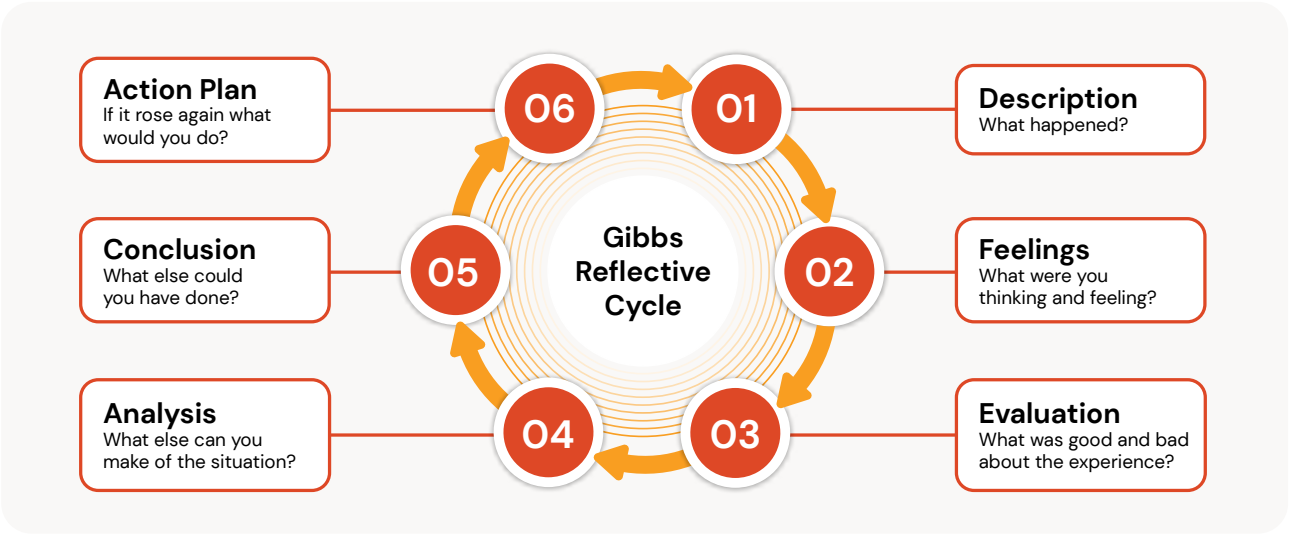
STEP	DESCRIPTION
1	Decide which aspect of a program or intervention will be evaluated.
2	Describe what success would look like. Be specific and develop measurable indicators.
3	Develop some key evaluation questions that will enable measurement of the program/intervention outcomes against the desired theory of change. Examples include: • Was the program/intervention delivered as intended? • Did it reach the intended beneficiaries? • Did stakeholders adhere to agreed-upon implementation practice principles? • Were they any barriers or enablers to success? • To what extent did the program/intervention achieve its stated outcomes? • Did any unexpected results emerge from this work?
4	Work out what sort of data is required to answer the above evaluation questions and how it will be collected.
5	Analyse the data and answer the evaluation questions.
6	Share the findings in accessible formats, reflect on learnings and adjust the program/intervention and evaluation activities accordingly.

Who should lead evaluation activities?

As the commissioning agency, it's important that PHNs actively seek to embed evaluation activities in the programs and services they fund. Whether they opt to bring these activities in house or make them part of program or service delivery contracts is up to each individual PHN; however, at a minimum, PHNs should be active participants in the final step, which is focused on sharing and reflecting on the evaluation outcomes and using them to continuously improve suicide prevention interventions.

Reflection as continuous improvement

Ideally, evaluation will form part of an ongoing continuous improvement process, rather than being an isolated activity at the end of a program or intervention. One way to foster a culture of continuous improvement is to conduct simple reflection cycles during working group meetings. Here is an example of a reflection cycle you could implement.



Source: Gibbs' Reflective Cycle (1988) as cited by Crowe Associates Ltd (retrieved 2023).

Reflection cycles can be applied for a single activity, for a program as a whole, or for one or more underpinning processes. The end result of a reflection cycle should be agreement among participants about what can be done differently to further enhance the outcomes of the work.

3. Where to from here?

Addressing the challenge of veteran suicide is urgent work that has now been thrust into the national consciousness. For many PHNs and other mental health sector organisations, veteran suicide prevention is an emerging and unfamiliar space. As the landscape shifts in response to the Royal Commission, the need to engage and empower veterans in the face of a national crisis can feel overwhelming, particularly given the limited number of veteran suicide prevention interventions that have been trialled and evaluated in Australia to date. This toolkit seeks to equip PHNs with the fundamental knowledge and confidence to begin the important work of meaningfully supporting the wellbeing of a high-risk priority population, PHNs have a crucial opportunity to lead the way forward by educating their staff and service providers about veterans' unique needs and the importance of providing appropriate care to veterans and their families. We encourage our PHN colleagues to share this toolkit far and wide, as well as to encourage health care staff to attend education sessions about veteran health and mental health care, to read the outcomes of the Royal Commission and to consider their own roles in providing meaningful support to veterans across Australia.

Change takes time. Start with where you are, with what you know and with what you have. Even small actions can contribute to instrumental change that will lead to better suicide prevention outcomes for Australian veterans.

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