Submission

Royal Commission into Defence and Veteran Suicide

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Contents

1. Introduction

The Australian Psychological Society (APS) welcomes the opportunity to provide a response to the Royal Commission into Defence and Veteran Suicide. We are deeply concerned about the enduring mental health issues and suicides within the Australian Defence Force (ADF) and veteran community, and the wide-reaching impact on families, friends, colleagues and society at large.

We acknowledge the ongoing efforts by the ADF and Department of Veteran's Affairs (DVA) to better address mental health, well-being and suicide prevention and response for current and former ADF members. The recent *Interim Report* of the Royal Commission into Defence and Veteran Suicide (*Interim Report*)[1] has, however, brought to light deficiencies in the response efforts spanning numerous years, and despite more than 50 past inquiry reports and studies, including those specific to mental health and suicide [e.g., [2–4]].

The *Interim Report* identifies a number of urgent actions with the potential to impact the mental health, wellbeing and self-harm of current and former ADF personnel. In particular, the APS notes the following recommendations and urges the Government to provide adequate resources and support to immediately address them:

- **Legislative reform:** We agree that optimal change for veterans cannot be achieved without legislative change that clarifies the roles and responsibilities of stakeholders, particularly with regard to veteran compensation, rehabilitation and other entitlements. In addition, we advocate for plain language simplification of regulations and guidance that clearly describes veterans, families and kin entitlements to compensation and treatment.
- **DVA claims process:** We note the urgency to address the backlog of more than 41,000 DVA claims (as at May 2022)[1]. In addition, the way the DVA works with veterans, families and kin, for example, long wait times for claims approval and access to support, has the potential to cause additional stress and re-traumatisation and must be addressed.
- **Trauma-informed approach:** We strongly advocate for a trauma-informed approach to be always embedded in ADF and DVA information and support services. We agree with the Commission that this will require ongoing training in trauma-informed practices for all ADF and DVA personnel.

Recommendation 1

Provide adequate resources and support to urgently implement the recommendations set out in the *Interim Report* with the potential to impact the mental health, wellbeing and self-harm of veterans including: simplification of legislation, addressing the backlog of DVA claims and embedding a trauma-informed approach into all ADF and DVA information and support services.

As recognised in the Royal Commission's Terms of Reference, veteran suicide is a consequence of interacting and often dynamic biopsychosocial, environmental and situational factors that can occur prior to military service, during military service and/or post-military service and include military and non-military factors[1,5–7]. Thus, to shift the longstanding and alarming trends concerning veterans' mental health, wellbeing and suicide will not only require the urgent reforms identified in the *Interim Report*. Change will also require a sustained national investment in quality, person-centred, holistic lifetime care and support of veterans, their families and kin which is embedded into the ADF, DVA and other support agency structures, policies and initiatives - from the point of recruitment, throughout military service and during separation, transition and beyond.
Addressing suicide, suicidal ideation, attempted suicide (hereafter referred to as suicidality*) and associated mental health concerns, will also require strong internal leadership that models and supports actions to promote mental health and wellbeing and appropriately respond to psychological and other injuries that can result in self-harm.

Recommendation 2

Deeply embed a comprehensive approach to mental health care and suicide prevention and response within the ADF, DVA and other support agencies. This should include strengthening of protective factors, mitigation of risks and the provision of integrated non-clinical and clinical care focused on prevention through to recovery and postvention from the point of recruitment, throughout military service and during separation, transition and beyond.

* While we appreciate this language may not be used commonly outside academic and clinical contexts, for brevity we are using 'suicidality' to be a general term to refer to all suicide-related thoughts, behaviours and related mental health concerns. When reporting the outcomes of the Royal Commission, we suggest adherence to the *Mindframe Guidelines*[8].

2. List of Recommendations

Informed by the Royal Commission's Terms of Reference, the APS submission is organised thematically and makes a range of recommendations for reform and action in key areas. The recommendations included throughout our submission are summarised below for convenience.

Recommendation 1: Provide adequate resources and support to urgently implement the recommendations set out in the Interim Report with the potential to impact the mental health, wellbeing and self-harm of veterans including: simplification of legislation, addressing the backlog of DVA claims and embedding a trauma-informed approach into all ADF and DVA information and support services.

Recommendation 2: Deeply embed a comprehensive approach to mental health care and suicide prevention and response within the ADF, DVA and other support agencies. This should include strengthening of protective factors, mitigation of risks and the provision of integrated non-clinical and clinical care focused on prevention through to recovery and postvention from the point of recruitment, throughout military service and during separation, transition and beyond.

Recommendation 3: Incorporate trauma-informed care principles as part of organisational and operational decision-making in the ADF, DVA and other agencies.

Recommendation 4: Ensure the availability of timely psychological expertise to address the complex emotional responses, for example, to trauma and moral injury in affected veterans.

Recommendation 5: Support increased longitudinal research into predisposing risks as well as protective factors in suicidality in current and former military personnel.

Recommendation 6: Establish dedicated support to assist veterans (and their families) to navigate and stay engaged with quality, mainstream healthcare services that provide evidence-based treatment.

Recommendation 7: Address mental health and suicide stigma in military culture to remove barriers to help-seeking behaviour, and further, to promote a culture that encourages help-seeking behaviour.

Recommendation 8: Identify veterans as a vulnerable group requiring targeted policies and initiatives that support their access to mainstream services, for example, housing support.

Recommendation 9: Invest in more research and implementation of evidence-based initiatives to prevent and respond to veteran contact with the criminal justice system.

Recommendation 10: Dedicate a 'stream' of appropriate psychological support for those who experience military sexual trauma.

Recommendation 11: Encourage and strengthen current efforts to investigate and address all types of abuse, discrimination and bullying in the military, in particular while considering a diversity of characteristics and attributes including gender status, cultural background, preference and identity, beliefs, attitudes, skills, vulnerabilities and perceived weaknesses and attitudes.

Recommendation 12: Ensure veterans, their families and kin have timely access to evidenced based mental health and suicide care that operates within a non-stigmatising, person-centred stepped care model that aligns with an individual's needs and enables flexibility to transition seamlessly between different levels of support, ranging from low to high intensity, as those needs evolve.

Recommendation 13: The ADF and DVA partner with the APS, psychological scientists and field experts to build and implement systems that support the delivery of evidence-based mental health and suicide prevention and response practices for veterans, their families and kin, including:

- Develop clear statements of expectations or standards of mental health and suicide care commensurate with contemporary evidence-based practice.
- Implement mental health workforce incentives that drive best practice mental health and suicide care.
- Increase the availability of expert mental health advisors/panels to provide support and practice guidance for mental health practitioners.
- Coproduce training programs with those who have lived experience for early career mental health practitioners to develop military 'cultural competence' and support the continuing development of clinical skill requirements for evidence-based treatments for high-prevalence disorders in veterans.
- Provide funding for professional organisations (e.g., the APS) to develop and lead psychology intern and registrar programs with appropriate supervision focused on evidenced-based mental health and suicide care for veterans, their families and kin which will help to meet the demands now and into the future for highly skilled mental health practitioners available to work with this population.

Recommendation 14: Codesign and implement a robust system of clinical governance and quality assurance across the ADF and DVA for mental health and suicide prevention care for veterans, their families and kin, including:

- Resource the development and implementation of a robust case management system for complex veteran care cases.
- Create clinical panels to review mental health cases for quality compliance as required.
- Ensure mental health practitioners have qualifications and training appropriate to treating mental health concerns for veterans and their families.
- Implement robust outcomes measurement and evaluation of mental health and suicide prevention care provided to veterans, their families and kin.

Recommendation 15: The DVA to urgently review and increase the scheduled fee for all registered psychologists who participate in their Non-Liability Health Care Scheme.

Recommendation 16: Include, as part of a comprehensive suicide reduction strategy, a focus on known contextual factors and groups and subgroups identified as higher risk when transitioning out of military service.

Recommendation 17: Review the adequacy of the duration, intensity and nature of transition support provided by the DVA and other agencies to ensure it effectively addresses critically important practical and psychological considerations in a proactive manner.

Recommendation 18: Ensure ongoing assessment and monitoring for early identification and engagement in evidence-based care and connecting to services for transitioned ADF members and their families.

Recommendation 19: Strengthen efforts to develop alternative workplace injury and rehabilitation models for individuals with service-related injuries that aim to support the return of defence members to the same or alternative ADF roles.

Recommendation 20: Adopt a preventative, cross-department, whole-of-government approach to support families and kin, particularly to assist them when veterans transition out of the military.

3. About the APS

The Australian Psychological Society (APS) is the leading professional association for psychologists in Australia, representing over 28,000 members nationally. The APS is dedicated to advancing the scientific discipline and ethical practice of psychology and works to realise the full human potential of individuals, organisations and their communities through the application of psychological science and knowledge.

Our work is informed by the United Nations' Sustainable Development Goals[9], which champion wellbeing, inclusivity and the empowerment of all people, including veterans, their families and kin. By advocating on behalf of our members and the community, we strive to bring about meaningful reform in Australian health, wellbeing and social policies and systems. Our overarching objective is to ensure equitable access for all to quality, evidence-based services that promote health and well-being through proactive measures, prevention, early intervention and treatment[10,11].

As proponents of evidence-based practice, the APS has drawn on data and research about the characteristics, impacts and best practices related to suicidality in the Australian veteran population. Where possible, we have also drawn upon the clinical experience of APS members working with veterans in the preparation of this response.

4. Psychologists and Veteran Mental Health and Suicide Care

There are more than 36,000 registered psychologists and 7,800 provisional psychologists in Australia[12]. Psychologists are regulated by the Psychology Board of Australia, which sets the scope of practice, ethical standards and continuing professional development applicable to psychology practitioners. To become a registered psychologist requires at least a Masters degree with supervised practice. Many psychologists have additional training and one or more recognised Areas of Practice Endorsement. Psychology is a diverse profession, and our members work in a variety of capacities and settings throughout Australia, including for the ADF, Open Arms Veterans and Families Counselling Service via the DVA.

Defence and veteran services provided by psychologists include:

- Conducting psychological assessments of ADF candidates and providing evidence-based recommendations for recruitment and officer selection decisions.
- Providing specialised in-service mental health assessment and treatment to ADF personnel.
- Conducting trauma-informed psychological screening at key transition points (e.g., at the end of deployments).
- Providing psychological support and interventions to family members of ADF personnel.
- Providing specialist psychological advice on organisational, operational and personnel management decisions and policies.
- Developing initiatives based on expert psychological advice to enhance the performance, capability and effectiveness of the ADF.
- Providing psychological assessment and treatment to ADF veterans across multiple contexts, including through DVA, Open Arms and other mainstream mental health services. Such support covers the entire spectrum of addressing suicidality from prevention, early intervention, treatment, and postvention.
- Supporting family members of veterans through psychological interventions and resources.
- Conducting psychological research into the mental health, wellbeing, resilience and capability of ADF personnel.

5. Themed Response 1: Responding to Suicidal Vulnerability, Risk and Protective Factors in the Veteran Population

i. Trauma-informed care

There are protective and rehabilitative factors for preventing suicidality among current and former military members. While veterans are in service, they benefit from protective factors that mitigate the risk of mental health issues and suicidality that are inherent in military life and culture. These protective factors include: a strong sense of purpose and duty, mateship and camaraderie, physical and psychological hardiness and readily available healthcare[13].

Conversely, other aspects of military life, such as extended separations from family and frequent relocations can increase mental health risk. Exposure to injury, trauma or potentially traumatic events (PTEs) (during combat, peace-keeping or humanitarian operations) can increase the risk of mental health problems[13]. As clearly set out in a literature review undertaken by Phoenix Australia[14], a range of disorders affects a significant minority of current and ex-serving personnel with PTEs, and PTSD[15] being commonly associated with service[16].

Recommendation 3

Incorporate trauma-informed care principles as part of organisational and operational decision-making in the ADF, DVA and other agencies.

ii. Moral injury, PTSD, and anger

While trauma can severely impact mental health, it is not the only factor influencing suicidality. Other events experienced during military service (such as sexual assault, bullying and discrimination) and how ADF members are treated by their superiors and peers across their career are critically important, as highlighted in the *Interim Report*[1].

One such factor is moral injury which is an emerging psychological concept related to, but distinct from, PTSD and other experienced trauma[17]. Moral injury is exposure to experiences (either directly to an individual, caused by an individual, or witnessed) which 'transgress' a person's moral code or deeply-held conceptualisations about what is right or wrong[18]. Failure to act to prevent such psychological injury by addressing known hazards may be experienced as 'betrayal' [see 19]. Critically, there is a growing body of recent research which shows a clear association between moral injury and suicidality[17]. Given this, we suggest additional research to add to this emerging field in order to appropriately address moral injury within military contexts.

Another contributing problem is the presence and intensity of anger experienced by current and ex-serving ADF personnel. Anger can be intimately associated with suicidality within the military community where anger and PTSD co-exist[20]. Research and clinical experience point to the compounding effects of PTSD, depression, problem anger and substance abuse in terms of an increased risk of suicide.

Anger has been identified as a moral emotion that is a response to perceived failure to meet responsibility and social norms and is concerned with norm enforcement[19]. Importantly, anger has been shown to affect the success of PTSD and other trauma-relevant treatments with some suggesting it must be addressed before other treatment can begin[21,22]. Anger can contribute to negatively reinforcing effects on all relationships including those with family members and others outside the military[20,23,24]. Additionally, as observed by McHugh and Bates[19] in betrayal-based moral injury, "anger is directed at another person who is perceived as having perpetrated a betrayal resulting in the injury or worse of associates" [19 para 13].

Given the association between anger, moral injury, trauma and suicidality in current and ex-serving military personnel[17,22,24], the APS specifically encourages the Royal Commission to pay attention to the role of psychological factors in the veteran community and ensure that there is sufficient psychological expertise to address them in a timely fashion. We also call for more funded research into how these factors affect suicidality.

Recommendation 4

Ensure the availability of timely psychological expertise to address the complex emotional responses, for example, to trauma and moral injury in affected veterans.

Recommendation 5

Support increased longitudinal research into predisposing risks as well as protective factors in suicidality in current and former military personnel.

iii. Impact of separation from the military

The risk of suicide is not consistent for all who serve in the military. Illustrative of this, the AIHW Transition and Wellbeing Research Programme[25] identified a difference in the incidence of suicide between current serving personnel and veterans, and male and female service personnel - with current serving personnel (including reservists) having a 49% or 46% (respectively) lower rate of suicide, while ex-serving military experience personnel have a conversely higher rate of suicide when compared to the general population (27% higher for men and 107% higher for women)[23†].

> *"While most ADF members successfully transition and quickly re-establish civilian lives, some struggle to address the challenges they experience when they leave the military. Those discharged involuntarily can be deeply affected. And sometimes the impacts of service do not become apparent until many years after discharge. The health and wellbeing of family members of serving and ex-serving veterans can also be harmed by a veteran's military service, especially the families of veterans who died as a consequence of service and families living with veterans with physical injuries, disease or a mental illness."* [13(p. 4)]

Consistent with the literature pertaining to recovery from traumatisation, post-military experience (and the transition period which bridges it and civilian life) may have the greatest influence on the mental health of ex-serving personnel and their risk for suicidality. The marked difference in the suicide rate between current and former members of the military suggests that separation from the defence force poses a significant challenge for many veterans[27].

As is already well known to the Royal Commission, there are many demographic and service-related factors (such as gender, medical status, age, rank, length of service and serving overseas) that are associated with a higher post-transition suicide risk[2,23,28,29]. This suggests that tailored responses may be necessary to provide greater support to higher risk groups.

We suggest that there are multiple factors which may contribute to the vulnerability of veterans including:

1. **Loss of protective factors**: Once veterans transition out of the ADF they lose the protective factors that supported them during their service[27], increasing their vulnerability to poor mental health and suicidality.
2. **Reduced help seeking**: Military culture often adheres to traditional masculine norms, leading to a reluctance to seek help due to the perceived stigma associated with acknowledging mental health vulnerability [see 30,31]. It is also important to acknowledge other barriers to seeking care such as a preference for self-management (which is valued in the military), may delay help seeking until the realisation that it cannot be resolved alone[32,33].
3. **Lower levels of engagement**: In contrast to the previous point, the DVA Pathways to Care Report[2] found that 75% of veterans who reported they had mental health concerns sought and received assistance at some point from a GP or mental health professional. These rates exceed those observed in the general community, which indicates a positive willingness among veterans to seek healthcare. Yet the DVA Pathways to Care Report[2] also found that only 24% of veterans with mental health conditions received evidence supported mental health interventions in the prior 12 months. This suggests veterans might not remain engaged long enough to receive adequate evidence-based treatments[34]. Post-transition, issues may not be picked up by routine screening and assessment processes. Given this, we advocate for veterans to be supported to engage in mainstream healthcare services.

† It is important to note, however, that it may not be appropriate to compare members who are discharged involuntarily with people who have experienced work disability[26].

4. **Far reaching impacts of transition:** The change from military to post-military life can have a profound impact on an individual including their social connections, family dynamics and roles, income, location, responsibilities, daily routine, and culture[2,35]. Transition can also exacerbate the impacts of prior trauma[35].
5. **Experience of loss of positive military experiences and values:** The impact of discharge is not difficult to understand, given the military experience is one founded (at least on the notion of) mateship, team cohesion, a sense of belonging, adherence to duty, identity and a sense-of-purpose. Thus, our members working with this population have reported a palpable loss of meaning, identity, and/or direction in veterans' day-to-day lives post discharge [see also 27].
6. **Difficulties accessing institutionalised support**: There is evidence to suggest that veterans may struggle to engage with mainstream services. Critically, homelessness is unfortunately a common experience of veterans[36] which can also contribute to poor mental health outcomes. As another example, veterans reported feeling isolated on university campuses and/or described their university as not "veteran friendly"[37].
7. **Contact with the criminal justice system**: Research suggests that approximately 3% of veterans are arrested soon after leaving the military[2,38]. We know from other research, that there is inadequate psychological support in prisons to properly address trauma which can support a cycle of reoffending[39,40]. The APS advocates for appropriate consideration of this issue which may include the development of specialist veteran courts similar to the UK and US[38,41].

Psychologists are uniquely placed to assist individuals to cope with major life changes and challenges, such as transitioning out of military life. We recommend that psychological expertise is utilised to develop and evaluate transition programs (co-produced with veterans with lived experience) to adequately prepare individuals and build resilience to the challenges ahead, maintain their mental health and wellbeing, whilst providing support to access mainstream services. Critically, this must begin before transition takes place.

Recommendation 6

Establish dedicated support to assist veterans (and their families) to navigate and stay engaged with quality, mainstream healthcare services that provide evidence-based treatment.

Recommendation 7

Address mental health and suicide stigma in military culture to remove barriers to help-seeking behaviour, and further, to promote a culture that encourages help-seeking behaviour.

Recommendation 8

Identify veterans as a vulnerable group requiring targeted policies and initiatives that support their access to mainstream services, for example, housing support.

Recommendation 9

Invest in more research and implementation of evidence-based initiatives to prevent and respond to veteran contact with the criminal justice system.

iv. Bullying, discrimination and abuse in military contexts

Devastatingly, there is clear evidence on the public record (including in the *Interim Report*) that some ADF members suffer bullying and abuse during their time serving in the military[1,42]. There is emerging evidence that military-related bullying and hazing as well as military sexual trauma (MST) is associated with a range of poor mental health outcomes including suicidality[43–46]. People who experience MST are likely to require particular psychological care and, ideally, they should have dedicated access to appropriate expert support.

There must be zero tolerance for abuse at any stage of military life. We lament that such abuse and neglect must again be a focus of enquiry but believe that the Royal Commission is rightly placed to do so. We do acknowledge that the ADF have made an effort to address military abuse in recent years, however, we advocate for these initiatives to be strengthened while examining the unique and interacting contributions of military culture and the role of leadership.

One factor that may otherwise be overlooked is the effect of more subtle and institutionalised discrimination. It is well established in that discrimination[‡] is damaging both physically and psychologically[47–49]. However, it is important to acknowledge that research investigating discrimination is likely to have underestimated its effects as they are typically cross-sectional[50,51] and relational in nature. Evidence from cognitive neuroscientific research shows that discrimination has neural sequalae which are akin to chronic social stress which impacts upon critical brain structures including the pre-frontal cortex[52]. In addition, evidence suggests that cumulative exposure to discrimination is particularly challenging and damaging to mental health and wellbeing[48,50,53].

There is evidence that discrimination is related to:

- **Poor mental health** – Higher reported exposure to racial and disability discrimination is associated with lower mental health[50,54–56]. For example, women who experienced sex discrimination were three times more likely to report having PTSD symptoms[57] and/or to be clinically depressed with these latter outcomes appearing to persist over time[58].
- **Greater suicidality** – evidence suggests that there is a small but significant association between discrimination and suicidality[59,60].

Together, these results highlight the critical need to reduce the prevalence of all forms of discrimination, in both private and public settings, as a matter of public health[61,62].

The relationship between discrimination and health outcomes are further complicated by the compounding effect of intersectional disadvantage[61,63]. When individuals have more than one attribute associated with discrimination (for example being a member of an ethnic or religious minority, having a disability, identifying as having female or non-binary gender, or member of the LGBTIQA+ community), the impacts of discrimination can overlap and amplify [see 64]. Importantly, a sizable number of veterans return with a disability[65] so the issues of intersectionality may be particularly relevant to the military context.

Despite increasing awareness and decreasing social acceptance of discrimination, it is still pervasive and can be difficult to identify[62]. There is growing evidence highlighting the importance of subtle or 'ambiguous' forms of discrimination in predicting mental (ill) wellbeing[66]. In a large meta-analysis, covert discrimination was found to be at least as damaging as overt discrimination in a range of psychological, physical and work-related domains[67].

Further evidence highlighting the importance of reducing discrimination and harassment is the effects on bystanders who witness the harassment of others. Likened to 'second hand smoke', there

[‡]These studies specifically refer to discrimination, whereas there are many more which address the mental and physical effects of racism, a related but distinct concept.

is evidence to suggest that awareness of racial harassment (biased behaviours and offensive comments) in the workplace was associated with psychological strain and predicted negative job attitudes for all participants, particularly if the organisation was perceived to tolerate the harassment[66]. This was not the case for more 'blatant' forms of threats or assaults which are presumably less subtle and more likely to be addressed. Unfortunately, subtle forms of discrimination are often overlooked or normalised which has led to the term 'everyday sexism or discrimination'[62]. If it is perceived, therefore, that discrimination is tolerated in the ADF, then this has the potential to affect both the direct victims of the discrimination as well as those who observe it.

Recommendation 10

Dedicate a 'stream' of appropriate psychological support for those who experience military sexual trauma.

Recommendation 11

Encourage and strengthen current efforts to investigate and address all types of abuse, discrimination and bullying in the military, in particular while considering a diversity of characteristics and attributes including gender status, cultural background, preference and identity, beliefs, attitudes, skills, vulnerabilities and perceived weaknesses and attitudes.

6. Themed Response 2: Improving Veteran Access to Safe, Quality Mental Health and Suicide Care

i. Raising the bar for evidence-based veterans' mental health and suicide care

Current and ex-serving military personnel, their families and kin should expect a culturally aligned, quality-assured, evidence-driven and well-implemented system of care capable of addressing the factors associated with poor mental health and suicidality. Psychologists already play an important role in the veteran's mental health care ecosystem, as we have noted in earlier sections of this submission. As described in the *Interim Report*, however, concerns about timely and sufficient access to appropriate mental health care and continuity of care have been reported to the Commission. There were also some indications in the *Interim Report* that psychologists might not consistently receive the necessary support from the system to tailor their engagement with veterans, their families, and kin according to individual need, as opposed to organisational priorities or reputation.

This aligns with the findings of the recent 2019 Australian Productivity Commission inquiry into the veteran care system which found that, despite some improvements and overall generosity of funding, the system is outdated and is not working in the best interests of veterans, their families, kin or the Australian community[13]. The report highlighted the need to align the veteran care system towards a person-centred, holistic care and support model that aims to promote wellness, prevent harm and rehabilitate for participation in employment and life, as well as compensate for and treat illness and injury[13]. The Australian Productivity Commission also highlighted the need for more evidence-based treatment and efficient and effective governance and administrative arrangements[13].

The APS is a strong advocate for contemporary evidence-based practices in mental health care and suicide prevention and response. This involves combining the latest research findings, clinical expertise, and patient preferences. Additionally, we endorse non-stigmatising and person-centred stepped care models for mental health and suicide care. These models adapt care to individual needs, allowing seamless transitions between different support levels, from low to high intensity, as needs change.

Recommendation 12

Ensure veterans, their families and kin have timely access to evidenced based mental health and suicide care that operates within a non-stigmatising, person-centred stepped care model that aligns with an individual's needs and enables flexibility to transition seamlessly between different levels of support, ranging from low to high intensity, as those needs evolve.

The APS affirms that effective mental health care and suicide prevention and response must also be informed by an understanding of people and communities within systems, in this case the veterans community. This involves understanding and strengthening the interpersonal relationships which underpin the systems in which veterans, their families and kin live and work – as well as addressing the isolation or absence of meaningful relationships which are needed for healthful systems, communities and people. A systems-based approach also requires us to recognise and address harmful dynamics of power which increase vulnerability or impede recovery.

To enhance access of veterans, their families, and kin to quality and safe care as described above will require more investment to attract, retain and support a sufficient psychology workforce. In the recommendations below, we highlight a number of key considerations towards achieving this change through leveraging the expertise of psychologists.

Recommendation 13

The ADF and DVA partner with the APS, psychological scientists and field experts to build and implement systems that support the delivery of evidence-based mental health and suicide prevention and response practices for veterans, their families and kin, including:

- Develop clear statements of expectations or standards of mental health and suicide care commensurate with contemporary evidence-based practice.
- Implement mental health workforce incentives that drive best practice mental health and suicide care.
- Increase the availability of expert mental health advisors/panels to provide support and practice guidance for mental health practitioners.
- Coproduce training programs with those who have lived experience for early career mental health practitioners to develop military 'cultural competence' and support the continuing development of clinical skill requirements for evidence-based treatments for high-prevalence disorders in veterans.
- Provide funding for professional organisations (e.g., the APS) to develop and lead psychology intern and registrar programs with appropriate supervision focused on evidenced-based mental health and suicide care for veterans, their families and kin which will help to meet the demands now and into the future for highly skilled mental health practitioners available to work with this population.

Recommendation 14

Codesign and implement a robust system of clinical governance and quality assurance across the ADF and DVA for mental health and suicide prevention care for veterans, their families and kin, including:

- Resource the development and implementation of a robust case management system for complex veteran care cases.
- Create clinical panels that review mental health cases for quality compliance as required.
- Ensure mental health practitioners have qualifications and training appropriate to treating mental health concerns for veterans and their families.
- Implement robust outcomes measurement and evaluation of mental health and suicide prevention care provided to veterans, their families and kin.

ii. Unlocking veteran access to expert mental health professionals by increasing the DVA scheduled fee

Psychologists as experts in mental health and wellbeing are integral to the veteran's mental health workforce, particularly in the areas of evidence-based assessment, diagnosis and treatment. Yet, veterans have identified difficulties accessing mental health professionals such as psychologists under the DVA's Non-Liability Health Care Scheme (see e.g.,[68]) who, despite expertise and passion for serving the veteran population, cannot viably provide services at the DVA scheduled fee rate.

The APS has been concerned about the variation in psychology fees across compensable schemes in Australia, noting that DVA scheduled fees[69] at $153.35 (50+ minutes, in rooms) for psychologists and $225.10 (50+ minutes, in rooms) for clinical psychologists are among the lowest of all the compensable schemes and less than half of the APS National Schedule of Recommended Fees for psychological services. From 1 July 2023 until 30 June 2024, the APS recommended psychology fee is $300 for a 46–60-minute consultation. The DVA's very low scheduled fee, along with the high administrative burdens for practitioners acts as a disincentive for psychologists to participate in the Scheme (including psychologists holding endorsement in clinical, counselling, neuropsychology or health psychology). This is particularly concerning in the context of a higher demand for psychological services within the general community since the COVID pandemic[70].

For the Scheme to deliver high quality psychological treatment to veterans and their families, it is essential that the fees enable participation by psychologists who have the experience to provide best practice evidenced-based psychological interventions for veterans, their families and kin.

Without urgent review and increase of the scheduled fee more veterans and their families are at risk of being on longer waiting lists or missing out on services altogether.

Recommendation 15

The DVA needs to urgently review and increase the scheduled fee for all registered psychologists who participate in the Non-Liability Health Care Scheme.

iii. Need for supportive and effective military transition

There is evidence to suggest that not all veterans are adequately prepared for life outside of the ADF. The DVA Transition and Wellbeing study (2018) study highlights that the risk of developing mental ill-health concerns and suicidality increases during the first several years following transition, particularly for those who experience mental and physical symptoms[2]. There are also critical periods post-discharge when the risk of suicide increases. These include the breakdown of marital relationships among veterans, and estrangement from family and social networks due to issues like substance abuse or anger[23].

We note that there is increasing attention given to how to best prepare ADF members for life after military service, for example, comprehensive mental health assessment at the time of transition (which should particularly assess suicidality). In addition to assessment at the time of transition, it is vital to continue to monitor veterans, and their families, for several years post-service.

The social determinants of health also have a significant and direct impact on health and wellbeing[71]. Because of this, the prevalence of mental ill-health is skewed toward segments of the community with lower socio-economic status (SES) and the deficits which accompany it (e.g., lower education levels and underemployment and unemployment, inadequate housing, poorer health and mental health status). It is well understood that housing, employment and financial difficulties are implicated in the development and maintenance of veteran mental ill-health and suicidality.

If this this is to be addressed, the importance of all stakeholders (veterans, their families, health practitioners and their professional bodies, DVA and other agency staff) contributing to active help seeking and holistic and seamless care cannot be over-emphasised. This will inevitably involve a whole-of-government response.

Given this, we suggest there is a need to review the adequacy of the duration, intensity and nature of transition support provided so that it may not only act prophylactically to more effectively address critically important practical considerations but also the grief, loss and, too often, injustice-related anger veterans experience and manifest post termination of their military careers.

We suggest the following elements should be considered when optimising transition arrangements for ADF personnel:

- Social and family support
- Financial assistance
- Housing
- Employment opportunities

We also urge the Royal Commission to scrutinise the ADF's decision-making process and rationale regarding discharging members due to mental ill-health. While we acknowledge recent efforts in this regard (including the extension of Medical Employment Classification (MEC) status), we highlight the additional needs for support provided to individuals with service-related injuries. In particular, we draw attention to:

a) whether the ADF has on each and every occasion acted reasonably as an employer when discharging members due to a mental health impairment, and

b) the legitimacy of terminating an individual's service due to an injury sustained while in the ADF and what is reasonable in terms of the support they may be given to enable them to remain "in service", including the opportunity to be trained and redeployed to an alternative, more suitable ADF position.

As noted in an earlier section, much remains to be done in developing evidence-based psychological support before transition to ensure there are appropriate standards of care commensurate with best practice and sufficient clinical governance and quality assurance mechanisms. Post-discharge services also lack the specialisation needed for effective psychological intervention to reduce suicidality risk among veterans. A greater psychological workforce would assist to address these issues.

Recommendation 16

Include, as part of a comprehensive suicide reduction strategy, a focus on known contextual factors and groups and subgroups identified as higher risk when transitioning out of military service.

Recommendation 17

Review the adequacy of the duration, intensity and nature of transition support provided by the DVA and other agencies to ensure it effectively addresses critically important practical and psychological considerations in a proactive manner.

Recommendation 18

Ensure ongoing assessment and monitoring for early identification and engagement in evidence-based care and connecting to services for transitioned ADF members and their families.

Recommendation 19

Strengthen efforts to develop alternative workplace injury and rehabilitation models for individuals with service-related injuries that aim to support the return of defence members to the same or alternative ADF roles.

iv. Ensuring care and support for families and kin

The impetus for this Royal Commission has been the grief experienced by families of veterans who have died by suicide. They have sought this Royal Commission on the grounds that they have been unable to obtain meaningful responses to their enquires. The testimony given by many of those who have experienced the loss of child, partner or parent during or post military service has been clearly heard by the Royal Commission and we support their efforts to advocate on behalf of their family and kin.

Typically, they have highlighted the problems of:

- the absence of information,
- their frustration at dealing with Government departments, and
- feeling powerless in their attempt to assist their loved ones.

As highlighted in the previous section, a cross departmental and whole-of-Government approach (State/Territory and Federal) is necessary to ensure that veteran families and kin are appropriately supported. This includes the creation, provision and dissemination of educative and skill building resources for all key stakeholders, but especially families, around how to navigate and successfully address the range of needs and challenges that veterans present with post discharge. As noted elsewhere, it will be particularly important that a significant element of this effort and those resources are targeted towards the need to act prophylactically with the aim to minimise the impact of veterans' transition from the military on the mental health and wellbeing of their family and kin.

Recommendation 20

Adopt a preventative, cross-department, whole-of-government approach to support families and kin, particularly to assist them when veterans transition out of the military.

References

1. Commonwealth of Australia. (2022). *Royal Commission into Defence and Veteran Suicide – Interim Report*. https://defenceveteransuicide.royalcommission.gov.au/system/files/2023-05/interim-report-dvsrc-may-2023.pdf
2. Van Hooff, M., Forbes, D., Lawrence-Wood, E., Hodson, S., Sadler, N., Benassi, H., Hansen, C., Grace, B., Avery, J., Searle, A., Iannon, M., Abraham, M., Baur, J., Varker, T., O'Donnell, M., Phelps, A., Frederickson, J., Sharp, M., & McFarlane, A. (2018). *Mental health prevalence and pathways to care summary report, Mental Health and Wellbeing Transition Study*. The Department of Defence and the Department of Veterans' Affairs. https://www.dva.gov.au/sites/default/files/twrp-summary-report.pdf
3. Parliament of Australia. (2017). *The constant battle: Suicide by veterans—Senate Inquiry by Foreign Affairs, Defence and Trade References Committee* (Australia). https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Foreign_Affairs_Defence_and_Trade/VeteranSuicide/Report/c03
4. McFarlane, A. C., Hodson, S. E., Van Hooff, M., & Davies, C. (2011). *Mental health in the Australian Defence Force: 2010 ADF Mental Health and Wellbeing Study: Full report*. Department of Defence. https://www.defence.gov.au/sites/default/files/2020-08/2010-ADF-MentalHealthPrevalenceStudy-Report.pdf
5. Klonsky, E. D., Saffer, B. Y., & Bryan, C. J. (2018). Ideation-to-action theories of suicide: A conceptual and empirical update. *Current Opinion in Psychology*, *22*, 38–43. https://doi.org/10.1016/j.copsyc.2017.07.020
6. *Behaviours & risk factors*. (2023, August 11). Australian Institute of Health and Welfare. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors
7. Hawton, K., & Van Heeringen, K. (2009). Suicide. *The Lancet*, *373*(9672), 1372–1381. https://doi.org/10.1016/S0140-6736(09)60372-X
8. Everymind. (2020). *Reporting suicide and mental ill-health: A Mindframe resource for media professionals*. https://mindframe.org.au/suicide/communicating-about-suicide/mindframe-guidelines
9. United Nations Department of Economic and Social Affairs. (2022). *Sustainable Development*. https://sdgs.un.org/
10. Australian Psychological Society. (2022). *Prevent, Respond, Adapt: Improving the mental health and wellbeing of all Australians—Pre-budget Submission 2022-23*. https://treasury.gov.au/sites/default/files/2022-03/258735_australian_psychological_society.pdf
11. Martin, L., & Carbone, S. (2022). *Better than cure? Why we should focus on prevention*. *InPsych*(44), 10–19.
12. Psychology Board of Australia. (2023). *Statistics*. https://www.psychologyboard.gov.au/About/Statistics.aspx
13. Productivity Commission. (2019). *A better way to support veterans: Overview and recommendations* (Report no. 93). https://www.pc.gov.au/inquiries/completed/veterans/report/veterans-overview.pdf
14. 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*. Phoenix Australia – Centre for Posttraumatic Mental Health. https://defenceveteransuicide.royalcommission.gov.au/system/files/exhibit/EXHIBIT%2001-05.02%20-%20EXP.0001.0020.0174%20-%20Defence%20and%20Veterans%20Suicide%20Literature%20Review%20Phoenix%20Australia.pdf
15. Rivers, W. H. (1918). W H R Rivers on the treatment of shell shock. *The Lancet, as Catalogued by The British Library*. https://www.bl.uk/collection-items/w-h-r-rivers-on-the-treatment-of-shell-shock-from-the-lancet
16. Department of Veterans' Affairs. (2022, October 17). *Let's talk about posttraumatic stress disorder…*. Department of Veterans' Affairs. https://www.dva.gov.au/newsroom/latest-news-veterans/lets-talk-about-posttraumatic-stress-disorder
17. Jamieson, N., Carey, L. B., Jamieson, A., & Maple, M. (2023). Examining the association between moral injury and suicidal behavior in military populations: A systematic review. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-023-01885-6
18. Jamieson, N., Usher, K., Maple, M., & Ratnarajah, D. (2020). Invisible wounds and suicide: Moral injury and veteran mental health. *International Journal of Mental Health Nursing*, *29*(2), 105–109. https://doi.org/10.1111/inm.12704

19. McHugh, A., & Bates, G. (2022). *The influence of anger and imagery on the maintenance and treatment of PTSD*. IntechOpen. https://www.intechopen.com/chapters/82107
20. U.S. Department of Veterans Affairs. (2022). *Anger and trauma* [General Information]. PTSD: National Center for PTSD. https://www.ptsd.va.gov/understand/related/anger.asp
21. Cowlishaw, S., Metcalf, O., Little, J., Hinton, M., Forbes, D., Varker, T., Agathos, J., Bryant, R. A., McFarlane, A. C., Hopwood, M., Phelps, A. J., Howard, A., Cooper, J., Dell, L., & O'Donnell, M. L. (2022). Cross-lagged analyses of anger and PTSD symptoms among veterans in treatment. *Psychological Trauma: Theory, Research, Practice and Policy*, *14*(2), 336–345. https://doi.org/10.1037/tra0001084
22. Dillon, K. H., Van Voorhees, E. E., Dennis, P. A., Glenn, J. J., Wilks, C. R., Morland, L. A., Beckham, J. C., & Elbogen, E. B. (2020). Anger mediates the relationship between posttraumatic stress disorder and suicidal ideation in veterans. *Journal of Affective Disorders*, *269*, 117–124. https://doi.org/10.1016/j.jad.2020.03.053
23. Australian Institute of Health and Welfare. (2022, November 16). *Serving and ex-serving Australian Defence Force members who have served since 1985: Suicide monitoring 1997 to 2020, Suicides by sex and service status group*. Veterans. https://www.aihw.gov.au/reports/veterans/serving-and-ex-serving-adf-suicide-monitoring-2022/contents/analysis/suicides-by-sex-and-service-status-group
24. Wilks, C. R., Khalifian, C. E., Glynn, S. M., & Morland, L. A. (2020). The association between anger experiences and expression and veteran suicidal thoughts in intimate couple relationships. *Journal of Clinical Psychology*, *76*(10), 1869–1881. https://doi.org/10.1002/jclp.22960
25. Department of Veterans' Affairs. (2020, September 3). *Transition and Wellbeing Research Programme*. Department of Veterans' Affairs. https://www.dva.gov.au/about-us/overview/research/transition-and-wellbeing-research-programme
26. Collie, A., & Gray, S. E. (2022). The relationship between work disability and subsequent suicide or self-harm: A scoping review. *PLOS Global Public Health*, *2*(12). https://doi.org/10.1371/journal.pgph.0000922
27. Becker, K., Abell, D., & McCormack, M. (2021, March 26). *For many military veterans, leaving the force is the biggest battle*. The Conversation. http://theconversation.com/for-many-military-veterans-leaving-the-force-is-the-biggest-battle-157774
28. Van Hooff, M., McFarlane, A. C., Davies, C. E., Searle, A. K., Fairweather-Schmidt, A. K., Verhagen, A., Benassi, H., & Hodson, S. E. (2014). The Australian Defence Force Mental Health Prevalence and Wellbeing Study: Design and methods. *European Journal of Psychotraumatology*, *5*(1), 23950. https://doi.org/10.3402/ejpt.v5.23950
29. Australian Bureau of Statistics. (2022). *National Study of Mental Health and Wellbeing, 2020-21*. https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release
30. Air Force Medical Service. (2021, May 19). *Reducing the stigma and encouraging mental health care in the military*. Air Force Medical Service. https://www.airforcemedicine.af.mil/News/Display/Article/2623543/reducing-the-stigma-and-encouraging-mental-health-care-in-the-military/https%3A%2F%2Fwww.airforcemedicine.af.mil%2FNews%2FDisplay%2FArticle%2F2623543%2Freducing-the-stigma-and-encouraging-mental-health-care-in-the-military%2F
31. Sharp, M.-L., Fear, N. T., Rona, R. J., Wessely, S., Greenberg, N., Jones, N., & Goodwin, L. (2015). Stigma as a barrier to seeking health care among military personnel with mental health problems. *Epidemiologic Reviews*, *37*, 144–162. https://doi.org/10.1093/epirev/mxu012
32. Stevelink, S. A. M., Jones, N., Jones, M., Dyball, D., Khera, C. K., Pernet, D., MacCrimmon, S., Murphy, D., Hull, L., Greenberg, N., MacManus, D., Goodwin, L., Sharp, M.-L., Wessely, S., Rona, R. J., & Fear, N. T. (2019). Do serving and ex-serving personnel of the UK armed forces seek help for perceived stress, emotional or mental health problems? *European Journal of Psychotraumatology*, *10*(1), 1556552. https://doi.org/10.1080/20008198.2018.1556552
33. Hitch, C., Toner, P., & Armour, C. (2023). Enablers and barriers to military veterans seeking help for mental health and alcohol difficulties: A systematic review of the quantitative evidence. *Journal of Health Services Research & Policy*, *28*(3), 197–211. https://doi.org/10.1177/13558196221149930
34. Sadler, N. (2019, November 20). *Veterans have poorer mental health than Australians overall. We could be serving them better*. The Conversation. http://theconversation.com/veterans-have-poorer-mental-health-than-australians-overall-we-could-be-serving-them-better-119525

35. Waddell, E., & Toole, K. (2019, December 3). *"Life just went to crap": Why army veterans are twice as likely to end up in prison*. The Conversation. http://theconversation.com/life-just-went-to-crap-why-army-veterans-are-twice-as-likely-to-end-up-in-prison-128129
36. Lawrence-Wood, E., Hilferty, F., Katz, I., & Hooff, M. V. (2019, September 29). *5,800 defence veterans homeless in Australia – that's more than we thought*. The Conversation. http://theconversation.com/5-800-defence-veterans-homeless-in-australia-thats-more-than-we-thought-123695
37. Harvey, A., & Andrewartha, L. (2018, August 8). *Why some veterans feel alienated on campus and how universities can help*. The Conversation. http://theconversation.com/why-some-veterans-feel-alienated-on-campus-and-how-universities-can-help-100603
38. Loughnan, A., Davidson, C., & Murray, S. (2022, February 14). *The Royal Commission must find ways to keep veterans out of jail*. The Conversation. http://theconversation.com/the-royal-commission-must-find-ways-to-keep-veterans-out-of-jail-176880
39. Meyer, S. (2016). *Women in prison: Histories of trauma and abuse highlight the need for specialised care*. The Conversation. http://theconversation.com/women-in-prison-histories-of-trauma-and-abuse-highlight-the-need-for-specialised-care-68668
40. Australian Psychological Society. (2021). *Submission to the Qld Women's Safety and Justice Taskforce—Discussion Paper 2*. https://psychology.org.au/psychology/advocacy/submissions/professional-practice/2021/submission-to-the-qld-women-s-safety-and-justi-(1)
41. Tsai, J., Finlay, A., Flatley, B., Kasprow, W. J., & Clark, S. (2018). A national study of veterans treatment court participants: Who benefits and who recidivates. *Administration and Policy in Mental Health*, *45*(2), 236–244. https://doi.org/10.1007/s10488-017-0816-z
42. Commonwealth of Australia. (2014). *Processes to support victims of abuse in Defence* (Australia). https://www.aph.gov.au/parliamentary_business/committees/senate/foreign_affairs_defence_and_trade/government_response_to_the_defence_abuse_response_taskforce_dart/report
43. Campbell-Sills, L., Sun, X., Kessler, R. C., Ursano, R. J., Jain, S., & Stein, M. B. (2023). Exposure to bullying or hazing during deployment and mental health outcomes among US army soldiers. *JAMA Network Open*, *6*(1), e2252109. https://doi.org/10.1001/jamanetworkopen.2022.52109
44. Kimerling, R., Makin-Byrd, K., Louzon, S., Ignacio, R. V., & McCarthy, J. F. (2016). Military sexual trauma and suicide mortality. *American Journal of Preventive Medicine*, *50*(6), 684–691. https://doi.org/10.1016/j.amepre.2015.10.019
45. Holliday, R., Nichter, B., Holder, N., Hill, M. L., Monteith, L. L., Norman, S. B., & Pietrzak, R. H. (2023). Childhood sexual abuse and military sexual trauma interact to increase suicide risk: Results from a nationally representative veteran sample. *Journal of Interpersonal Violence*, *38*(5–6), 5354–5369. https://doi.org/10.1177/08862605221120909
46. Galovski, T. E., McSweeney, L. B., Woolley, M. G., Alpert, E., & Nillni, Y. I. (2023). The relative impact of different types of military sexual trauma on long-term PTSD, depression, and suicidality. *Journal of Interpersonal Violence*, *38*(15–16), 9465–9491. https://doi.org/10.1177/08862605231168823
47. Pascoe, E. A., & Richman, L. S. (2009). Perceived Discrimination and Health: A Meta-Analytic Review. *Psychological Bulletin*, *135*(4), 531–554. https://doi.org/10.1037/a0016059
48. Ferdinand, A. S., Paradies, Y., & Kelaher, M. (2015). Mental health impacts of racial discrimination in Australian culturally and linguistically diverse communities: A cross-sectional survey. *BMC Public Health*, *15*(1), 401. https://doi.org/10.1186/s12889-015-1661-1
49. Centre of Research Excellence in Disability and Health. (2017, November 30). *How discrimination impacts on the health of people with disability*. https://credh.org.au/publications/fact-sheets/how-discrimination-impacts-on-the-health-of-people-with-disability/
50. Wallace, S., Nazroo, J., & Bécares, L. (2016). Cumulative Effect of Racial Discrimination on the Mental Health of Ethnic Minorities in the United Kingdom. *American Journal of Public Health*, *106*(7), 1294–1300. https://doi.org/10.2105/AJPH.2016.303121
51. Gee, G. C., Spencer, M., Chen, J., Yip, T., & Takeuchi, D. T. (2007). The association between self-reported racial discrimination and 12-month DSM-IV mental disorders among Asian Americans nationwide. *Social Science & Medicine (1982)*, *64*(10), 1984–1996. https://doi.org/10.1016/j.socscimed.2007.02.013
52. Berger, M., & Sarnyai, Z. (2015). "More than skin deep": Stress neurobiology and mental health consequences of racial discrimination. *Stress (Amsterdam, Netherlands)*, *18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204

53. Shepherd, C. C. J., Li, J., Cooper, M. N., Hopkins, K. D., & Farrant, B. M. (2017). The impact of racial discrimination on the health of Australian Indigenous children aged 5–10 years: Analysis of national longitudinal data. *International Journal for Equity in Health*, *16*(1), 116. https://doi.org/10.1186/s12939-017-0612-0
54. Australian Institute of Health and Welfare. (2020). *People with disability in Australia, Disability discrimination*. Australian Institute of Health and Welfare. https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia/contents/justice-and-safety/disability-discrimination
55. Harnois, C., & Bastos, J. L. (2018). *Sexism isn't just unfair; it makes women sick, study suggests*. The Conversation. http://theconversation.com/sexism-isnt-just-unfair-it-makes-women-sick-study-suggests-95689
56. Ziersch, A., Due, C., & Walsh, M. (2020). Discrimination: A health hazard for people from refugee and asylum-seeking backgrounds resettled in Australia. *BMC Public Health*, *20*(1), 108. https://doi.org/10.1186/s12889-019-8068-3
57. Berg, S. H. (2006). Everyday Sexism and Posttraumatic Stress Disorder in Women: A Correlational Study. *Violence Against Women*, *12*(10), 970–988. https://doi.org/10.1177/1077801206293082
58. Walker, R. (2019, September 9). *High levels of sexism could be fuelling poor mental health among women*. UCL News. https://www.ucl.ac.uk/news/2019/sep/high-levels-sexism-could-be-fuelling-poor-mental-health-among-women
59. Goodwill, J. R., Taylor, R. J., & Watkins, D. C. (2021). Everyday discrimination, depressive symptoms, and suicide ideation among African American men. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*, *25*(1), 74–93. https://doi.org/10.1080/13811118.2019.1660287
60. Coimbra, B. M., Hoeboer, C. M., Yik, J., Mello, A. F., Mello, M. F., & Olff, M. (2022). Meta-analysis of the effect of racial discrimination on suicidality. *SSM - Population Health*, *20*, 101283. https://doi.org/10.1016/j.ssmph.2022.101283
61. Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, *75*(12), 2099–2106. https://doi.org/10.1016/j.socscimed.2011.12.037
62. Alba, B. (2019). *Still serving guests while your male relatives relax? Everyday sexism like this hurts women's mental health*. The Conversation. http://theconversation.com/still-serving-guests-while-your-male-relatives-relax-everyday-sexism-like-this-hurts-womens-mental-health-116728
63. Bowleg, L. (2012). The Problem With the Phrase Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health. *American Journal of Public Health*, *102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750
64. Council of Europe. (2022). *Intersectionality and Multiple Discrimination*. Gender Matters. https://www.coe.int/en/web/gender-matters/intersectionality-and-multiple-discrimination
65. Clarke, P. (2016, March 17). *Bringing the war home: The rising disability claims of Afghanistan war vets*. The Conversation. http://theconversation.com/bringing-the-war-home-the-rising-disability-claims-of-afghanistan-war-vets-56021
66. Chrobot-Mason, D., Rose Ragins, B., & Linnehan, F. (2013). Second hand smoke: Ambient racial harassment at work. *Journal of Managerial Psychology*, *28*(5), 470–491. https://doi.org/10.1108/JMP-02-2012-0064
67. Jones, K. P., Peddie, C. I., Gilrane, V. L., King, E. B., & Gray, A. L. (2016). Not So Subtle: A Meta-Analytic Investigation of the Correlates of Subtle and Overt Discrimination. *Journal of Management*, *42*(6), 1588–1613. https://doi.org/10.1177/0149206313506466
68. Veterans' fully-funded mental health treatment "really great" on surface, but getting in door difficult. (2023, March 20). *ABC News*. https://www.abc.net.au/news/2023-03-21/veterans-call-for-better-access-to-dva-mental-health-support-/102111050
69. *Dental and allied health fee schedules*. (2023, August 9). Department of Veterans' Affairs. https://www.dva.gov.au/get-support/providers/notes-fee-schedules-and-guidelines/fee-schedules/dental-and-allied-health-fee-schedules
70. Australian Psychological Society. (2022, February 24). *1 in 3 psychologists are unable to see new clients, but Australians need help more than ever*. https://psychology.org.au/for-members/news-and-updates/news/2022/australians-need-psychological-help-more-than-ever
71. Australian Psychological Society. (2023). *Social determinants of health*. https://psychology.org.au/community/advocacy-social-issues/social-determinants-of-health#:~:text=The%20social%20determinants%20of%20health%20(SDOH)%20are%20the%20circumstances%20in,place%20to%20deal%20with%20illness.

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